APPROPRIATIONS COMMITTEE

Tuesday, February 9, 2016
3:00 PM – 6:00 PM
212 Knott Building

Meeting Packet

Revised

Steve Crisafulli
Speaker

Richard Corcoran
Chair

The Florida House of Representatives

Appropriations Committee

Steve Crisafulli
Speaker

Richard Corcoran
Chair

AGENDA

Tuesday, February 9, 2016
212 Knott Building
3:00 PM – 6:00 PM

I. Call to Order/Roll Call/Opening Remarks

II. **Consideration of the following bills:**

CS/HB 139 Dental Care by Health Quality Subcommittee, Cummings
CS/HB 221 Out-of-network Health Insurance Coverage by Insurance & Banking Subcommittee, Trujillo
HB 301 Property Prepared for Tax-Exempt Use by Burton
CS/HB 445 Viatical Settlements by Insurance & Banking Subcommittee, Stevenson
HB 461 Location of Utilities by Ingram, Campbell
CS/HB 761 Fraudulent Activities Associated with Payment Systems by Criminal Justice Subcommittee, Young
CS/HB 769 Mental Health Treatment by Children, Families & Seniors Subcommittee, Peters
HB 965 Firesafety by Harrison
HB 989 Implementation of Water and Land Conservation Constitutional Amendment by Harrell, Caldwell
HB 1169 Emergency Management by Powell
CS/HB 4065 Duties of the Legislative Auditing Committee by Government Operations Subcommittee, Raulerson
HB 7089 State Group Insurance Program by Health & Human Services Committee, Brodeur
HB 7095 Juror Costs by Judiciary Committee, Metz

III. **Consideration of the following proposed committee substitute:**

PCS for HB 873 -- Special Facility Construction Account

IV. Adjournment

221 The Capitol, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4810 Fax: (850) 488-9633

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 139 Dental Care
SPONSOR(S): Health Quality Subcommittee, Cummings and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 234

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	7 Y, 0 N, As CS	Guzzo	O'Callaghan
2) Appropriations Committee		Garner	Leznoff
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill requires the Department of Health (DOH) to develop and implement a dental care access account initiative (Initiative) to benefit dentists employed by a public health program or committed to opening a private practice capable of serving at least 1,200 patients in a dental health professional shortage area or medically underserved area.

The bill requires DOH to implement an electronic benefits transfer system enabling selected dentists to spend awarded funds on:

- Repayment of dental school student loans;
- Investment in property, facilities, or equipment required to establish and operate a dental office; and
- Transitional expenses associated with relocation or opening a dental practice.

The bill requires DOH to establish application procedures and selection criteria for the Initiative. An applicant may submit proof to DOH of having spent the capital to have made substantial progress in opening a dental practice to serve at least 1,200 patients. The bill limits the number of new dental care access accounts that may be established by DOH to no more than 10 per fiscal year. The bill authorizes DOH to further limit the number of applicants selected and give priority to dentists in areas with a higher need, as ranked by the Department of Economic Opportunity.

The bill states the funds needed to implement the Initiative are subject to a legislative appropriation. Each award may not be less than $10,000 or exceed $100,000. The bill authorizes local sources to contribute to a dental care access account, but no state award may exceed three times the amount contributed to an account in the same year from local sources. The bill specifies that a dentist's salary and employer expenditures from a public health program not funded by state dollars may constitute as local matching funds.

The bill directs DOH to close an account no later than five years after the first deposit or immediately if the dentist does not follow the requirements of, or no longer participates in, the Initiative and includes provisions for the return or reallocation of unspent funds. The bill requires DOH to create a process to verify if funds withdrawn from an account have been used for authorized purposes.

The bill requires DOH to develop and submit an annual report on the Initiative to the Governor and the Legislature.

The bill has a negative fiscal impact of $90,542 recurring and $19,766 nonrecurring on DOH and requires one full time equivalent position to administer the program. Under the bill criteria, the maximum state expenditure for ten grants at an award of $100,000 each is $1 million. There is no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services' Health Resources and Services Administration according to criteria developed in accordance with section 332 of the Public Health Services Act.[1] HPSA designations are used to identify areas and population groups within the U.S. that are experiencing a shortage of health care professionals.[2]

There are three categories of HPSA designation: primary care, dental, and mental health. A HPSA designation may be based on a geographic area, population group, or facility experiencing a shortage of health care providers or a lack of access to health care services. A geographic HPSA indicates that the entire area may experience barriers in accessing care, while a population HPSA indicates that a particular subpopulation of an area, such as homeless or low-income persons, may be underserved. A facility HPSA designation is granted to a unique facility that primarily cares for an underserved population. The primary factor used to determine a HPSA designation is the number of health care professionals relative to the population in a defined area.[3]

In the U.S., there are approximately 4,900 dental HPSAs. The threshold for a dental HPSA is a population-to-provider ratio of at least 5,000 to 1.[4]

Medically Underserved Area

Medically Underserved Areas (MUA) are also designated by the U.S. Department of Health and Human Services. These areas are designated using one of the three following methods and can be a whole county or group of contiguous counties, or census tracts:

- MUA Designation, which applies the Index of Medical Underservice (IMU) and calculates a score based on the:
  - Ratio of primary care physicians per 1,000 population;
  - Percentage of the population with incomes below the poverty level;
  - Infant mortality rate; and
  - Percentage of population age 65 and older.
- Medically Underserved Populations (MUP) Designation, which builds off data collected under the MUA designation process and reviews the ratio of primary care physicians serving the population seeking the designation. A MUP is a group of people who encounter economic or cultural barriers to primary health care services.
- Exceptional MUP Designation, which includes those population groups that do not meet the criteria of an IMU, but may be considered for designation because of unusual conditions.

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[1] Pub L. No. 107-251 codified at 42 U.S.C. s. 256(f).
[2] 42 C.F.R. §5.1; *see also* Health Resources and Services Administration, Guidelines for Primary Medical Care/Dental HPSA Designation, available at http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/medicaldentalhpsaguidelines.html (last visited December 14, 2015).
[3] Health Resources and Services Administration , Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations , available at http://www.hrsa.gov/shortage/ (last visited December 14, 2015).
[4] *Id.*

Requests for this designation must be requested by the Governor or another senior executive level official and local state health official.[5]

Cost of Dental Education

In the U.S., combined undergraduate and dental school debt jumped from $106,000 in 2000 to more than $220,000 in 2012, an increase of 109 percent in 12 years. Approximately two-thirds of all undergraduates and 90 percent of dental students rely on student loans to finance their degrees. Among all U.S. dental schools, the total cost of attendance over the past 10 years for four years of dental school rose dramatically—by 93 percent for in-state residents (from about $89,000 to $171,000) and by 82 percent for out-of-state residents (from $128,000 to $234,000).[6]

Unlike Florida, 30 states have a state dental student loan repayment program.[7] Those states may have an advantage in recruiting dentists to serve low-income populations or rural areas.

Access to Dental Care and Dental Workforce in Florida

Florida has a high population of residents who lack access to dental services; there are currently 218 designated dental HPSAs in Florida.[8] There is a noticeable shortage of dentists in certain parts of the state, especially in the central Panhandle counties and interior counties of south Florida. Most dentists are disproportionately concentrated in the more populous areas of the state. The ratio of dentists to Florida residents is approximately 1 to every 2,200 people.[9]

Lower patient densities, rural income disparities, and lower dental care reimbursement levels make it difficult to recruit and retain dentists in rural communities of the state. According to the most recent population data, 16.3 percent of Florida residents[10] were living below the poverty level.[11] The majority of these residents utilize dental public health programs[12] for their dental care, but only 1.4 percent of Florida dentists practice in public health programs and only 14 percent of Florida dentists accept Medicaid.[13] Only 27.4 percent of low-income Floridians have access to dental care.[14]

DOH provides dental care in some county health departments. According to DOH, there are currently 16 vacant dentist positions out of the 82 total positions within DOH.[15]

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[5] Health Resources and Services Administration, Medically Underserved Areas/Populations, available at http://www.hrsa.gov/shortage/mua/index.html (last visited December 14, 2015).
[6] American Dental Education Association, *A Report of the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing,*17 (March 2013), available at: http://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/publications/Documents/ADEACostandBorrowingReportMarch2013.pdf (last visited December 14, 2015).
[7] National Health Services Corps, State Loan Repayment Program, *State Loan Repayment Program Fact Sheet,* available at https://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/index.html (last visited December 14, 2015).
[8] National Health Services Corps, *State-by-State Guide,* available at http://nhsc.hrsa.gov/ambassadors/states/FL.html (last visited December 14, 2015).
[9] Florida Dep't of Health, *Report on the 2011-2012 Workforce Survey of Dentists*, April 2014, available at http://www.floridahealth.gov/programs-and-services/community-health/dental-health/workforce-reports/florida-workforce-survey-of-dental-hygienists-2011-2012.pdf. (last visited December 14, 2015).
[10] Florida Dep't of Health, Florida CHARTS, *Percentage of Individuals Living Below Poverty Level*, available at http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0294 (last visited December 14, 2015).
[11] This figure is $11,670 for an individual as defined by the US Department of Health and Human Services.
[12] "Public health program" includes a county health department, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the DOH. Section 381.0302(2)(e), F.S.
[13] Supra, FN 9 at pg. 6.
[14] Florida Dep't of Health, Florida Charts, Access to Dental Care by Low Income Persons 2012, available at http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0266 (December 14, 2015).
[15] Florida, Dep't of Health, *Legislative Bill Analysis HB 139* (September 23, 2015) (on file with Health Quality Subcommittee staff).

Effect of Proposed Changes

Florida Dental Care Access Account Initiative

HB 139 creates the dental care access account initiative (Initiative) to be implemented by the Department of Health (DOH). The Initiative is conditioned on the availability of funds to be appropriated by the Legislature and is intended to increase the number of dentists practicing in dental HPSAs or MUAs.

Eligible Dentists

The Initiative may benefit Florida licensed dentists who are:

- Actively employed by a public health program in a dental HPSA or a MUA; or
- Committed to opening a private practice in a dental HPSA or MUA by residing in the area, maintaining a Medicaid provider agreement, enrolling with one or more Medicaid managed care plans, expending capital to open an office to serve at least 1,200 patients, and obtaining community financial support.

Applications

The bill requires DOH to establish application procedures for dentists who wish to apply for a dental care access account (account). The bill allows an applicant to demonstrate in the application that he or she has spent sufficient capital to make progress in opening a dental practice that is capable of serving at least 1,200 patients by providing proof of:

- Contracts for the purchase or lease of a practice location; and
- Acquisition of at least 30 percent of the value of equipment and supplies necessary to operate a dental practice.

The bill limits the number of new dental care access accounts that may be established by DOH to no more than 10 per fiscal year. The bill authorizes DOH to further limit the number of applicants selected and give priority to practitioners in areas with a higher need, as ranked by the Department of Economic Opportunity. The bill also authorizes DOH to establish additional priority selection criteria.

Required Use of the Account

The bill requires DOH to establish individual dental care access accounts for selected dentists. The accounts will be managed through an electronic benefits transfer system that enables each participating dentist to spend funds for the following purposes:

- Repayment of dental school student loans;
- Investment in property, facilities, or equipment necessary to establish and operate a dental office consisting of at least two operatories; and
- Payment of transitional expenses related to the relocation or opening of a dental practice that are specifically approved by DOH.

The bill authorizes DOH to create a verification process to confirm that funds withdrawn from an account have been used for authorized purposes.

Account Monetary Limits

Subject to available state appropriations, the bill requires DOH to distribute funds in amounts of at least $10,000 but not to exceed $100,000 per account. The bill authorizes DOH to accept funds for deposit

into a designated account from local sources. No state award may exceed three times the amount contributed to an account in the same year from a local source.

The bill specifies that a dentist's salary and employer expenditures from a public health program not funded by state dollars may constitute local matching funds. State funds may not be included in a determination of the amount contributed from a local source.

Account Closure

HB 139 directs DOH to close an account no later than five years after the first deposit, or immediately if the dentist:

- No longer works for a public health program, unless the dentist opens a private practice in a dental HPSA or MUA within 30 days of no longer working for a public health program;
- No longer practices in a HPSA or MUA;
- Has been terminated from Medicaid; or
- Has participated in any fraudulent activity.

The bill authorizes DOH to award remaining state funds, after 5 years or from terminated accounts, to another account. A dentist is required to repay any funds withdrawn from the account after the occurrence of an event which requires account closure. The bill authorizes DOH to recover inappropriately spent funds through disciplinary enforcement actions and other methods authorized by law.

The bill also requires DOH to proportionately return unspent funds from donated sources that remain in a closed account to the appropriate donor source.

Reporting Requirements

The bill establishes a reporting process for the evaluation and accountability of the Initiative. Starting January 1, 2018, DOH must submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, which must include the:

- Number of patients served by Initiative participating dentists;
- Number of Medicaid recipients served by Initiative participating dentists;
- Average number of hours worked and patients served per week by Initiative participating dentists;
- Number of Initiative participating dentists in each dental health professional shortage area or medically underserved area;
- Amount and source of local matching funds received by DOH;
- Amount of state funds awarded to Initiative participating dentists; and
- Complete categorical accounting of the use of funds which may include:
    - Loans;
    - Supplies and equipment;
    - Rental property;
    - Real property purchases; and
    - Salary and wages.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 381.4019, F.S., relating to dental care access accounts.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has a negative fiscal impact on DOH of $90,542 recurring and $19,766 nonrecurring.[16] The cost estimates include a Senior Management Analyst II to review applications and award grants, manage accounts and compliance, submit program reports, and administer the initiative. The impact also includes contracted services of an electronic benefits transfer system vendor to support ten grant recipients at $31,250 in the initial year of the program and $15,625 each subsequent year.[17] Under the bill criteria, the maximum state expenditure for ten grants at an award of $100,000 each is $1 million.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Selected dentists will receive grants in amounts ranging from $10,000 to $100,000 per account. These funds will be utilized as loan repayment assistance and will realize cost reductions in their student loan debt. Such dentists will also be able to spend awarded funds on their business startup costs putting them in a more stable financial situation upon opening their practice.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to DOH to implement the Initiative.

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[16] Florida Dep't of Health, *Legislative Bill Analysis HB 139* (September 23, 2015) (on file with Health Quality Subcommittee staff). Analyzed utilizing only Senior Management Analyst II position and 10 grant recipients for the EBT contract rather than the anticipated 32.

[17] Id.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 11, 2016, the Health Quality Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The first amendment limited the number of new dental care access accounts that may be established by DOH to no more than 10 per fiscal year. The second amendment removed the requirement for DOH to develop a marketing plan for the dental care access account initiative.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1 A bill to be entitled
2 An act relating to dental care; creating s. 381.4019,
3 F.S.; establishing a joint local and state dental care
4 access account initiative, subject to the availability
5 of funding; authorizing the creation of dental care
6 access accounts; specifying the purpose of the
7 initiative; providing definitions; providing criteria
8 for the selection of dentists for participation in the
9 initiative; providing for the establishment of
10 accounts; limiting the number of new dental care
11 access accounts established per fiscal year; requiring
12 the Department of Health to implement an electronic
13 benefit transfer system; providing for the use of
14 funds deposited in the accounts; authorizing the
15 department to distribute state funds to accounts,
16 subject to legislative appropriation; authorizing the
17 department to accept contributions from local sources
18 for deposit in designated accounts; limiting the
19 number of years that an account may remain open;
20 providing for the immediate closure of accounts under
21 certain circumstances; authorizing the department to
22 transfer state funds remaining in a closed account at
23 a specified time; requiring the department to return
24 unspent funds from local sources; requiring a dentist
25 to repay funds in certain circumstances; authorizing
26 the department to pursue disciplinary enforcement

27 actions and to use other legal means to recover funds;
28 requiring the department to establish by rule
29 application procedures and a process to verify the use
30 of funds withdrawn from a dental care access account;
31 requiring the department to give priority to
32 applications from dentists practicing in certain
33 areas; requiring the Department of Economic
34 Opportunity to rank shortage areas and medically
35 underserved areas; requiring the Department of Health
36 to annually submit a report with certain information
37 to the Governor and the Legislature; requiring
38 rulemaking for the submission of information for such
39 reporting; providing an effective date.
40
41 Be It Enacted by the Legislature of the State of Florida:
42
43 Section 1. Section 381.4019, Florida Statutes, is created
44 to read:
45 381.4019 Dental care access accounts.—Subject to the
46 availability of funds, the Legislature establishes a joint local
47 and state dental care access account initiative and authorizes
48 the creation of dental care access accounts to promote economic
49 development by supporting qualified dentists who practice in
50 dental health professional shortage areas or medically
51 underserved areas or who treat a medically underserved
52 population. The Legislature recognizes that maintaining good

53 oral health is integral to overall health status and that the
54 good health of residents of this state is an important
55 contributing factor in economic development. Better health,
56 including better oral health, enables workers to be more
57 productive, reduces the burden of health care costs, and
58 improves the cognitive development of children.
59 (1) As used in this section, the term:
60 (a) "Dental health professional shortage area" means a
61 geographic area so designated by the Health Resources and
62 Services Administration of the United States Department of
63 Health and Human Services.
64 (b) "Department" means the Department of Health.
65 (c) "Medically underserved area" means a geographic area
66 so designated by the Health Resources and Services
67 Administration of the United States Department of Health and
68 Human Services.
69 (d) "Public health program" means a county health
70 department, the Children's Medical Services program, a federally
71 qualified community health center, a federally funded migrant
72 health center, or other publicly funded or nonprofit health care
73 program as designated by the department.
74 (2) The department shall develop and implement a dental
75 care access account initiative to benefit dentists licensed to
76 practice in this state who demonstrate, as required by the
77 department by rule:
78 (a) Active employment by a public health program located

79 in a dental health professional shortage area or a medically
80 underserved area; or
81 (b) A commitment to opening a private practice in a dental
82 health professional shortage area or a medically underserved
83 area evidenced by residing in the designated area, maintaining
84 an active Medicaid provider agreement, enrolling in one or more
85 Medicaid managed care plans, expending sufficient capital to
86 make substantial progress in opening a dental practice that is
87 capable of serving at least 1,200 patients, and obtaining
88 financial support from the local community in which the dentist
89 is practicing or intending to open a practice.
90 (3) The department shall establish dental care access
91 accounts as individual benefit accounts for each dentist who
92 satisfies the requirements of subsection (2) and is selected by
93 the department for participation. The department may not
94 establish more than 10 new dental care access accounts per
95 fiscal year. The department shall implement an electronic
96 benefits transfer system that enables each dentist to spend
97 funds from his or her account for the purposes described in
98 subsection (4).
99 (4) Funds contributed from state and local sources to a
100 dental care access account may be used for one or more of the
101 following purposes:
102 (a) Repayment of dental school student loans.
103 (b) Investment in property, facilities, or equipment
104 necessary to establish and operate a dental office consisting of

105 at least two operatories.
106 (c) Payment of transitional expenses related to the
107 relocation or opening of a dental practice which are
108 specifically approved by the department.
109 (5) Subject to legislative appropriation, the department
110 shall distribute state funds as an award to each dental care
111 access account. Such awards must be in an amount not more than
112 $100,000 and at least $10,000, except that a state award may not
113 exceed 3 times the amount contributed to an account in the same
114 year from local sources. If a dentist qualifies for a dental
115 care access account under paragraph (2)(a), the dentist's salary
116 and associated employer expenditures constitute a local match
117 and qualify the account for a state award if the salary and
118 associated expenditures do not come from state funds. State
119 funds may not be included in a determination of the amount
120 contributed to an account from local sources.
121 (6) The department may accept contributions of funds from
122 local sources for deposit in the account of a dentist designated
123 by the donor.
124 (7) The department shall close an account no later than 5
125 years after the first deposit of state or local funds into that
126 account or immediately upon the occurrence of any of the
127 following:
128 (a) Termination of the dentist's employment with a public
129 health program unless, within 30 days after such termination,
130 the dentist opens a private practice in a dental health

131 professional shortage area or medically underserved area.
132 (b) Termination of the dentist's practice in a designated
133 dental health professional shortage area or medically
134 underserved area.
135 (c) Termination of the dentist's participation in the
136 Florida Medicaid program.
137 (d) Participation by the dentist in any fraudulent
138 activity.
139 (8) Any state funds remaining in a closed account may be
140 awarded and transferred to another account concurrent with the
141 distribution of funds under the next legislative appropriation
142 for the initiative. The department shall return to the donor on
143 a pro rata basis unspent funds from local sources which remain
144 in a closed account.
145 (9) If the department determines that a dentist has
146 withdrawn account funds after the occurrence of an event
147 specified in subsection (7), has used funds for purposes not
148 authorized in subsection (4), or has not remained eligible for a
149 dental care access account for a minimum of 2 years, the dentist
150 shall repay the funds to his or her account. The department may
151 recover the withdrawn funds through disciplinary enforcement
152 actions and other methods authorized by law.
153 (10) The department shall establish by rule:
154 (a) Application procedures for dentists who wish to apply
155 for a dental care access account. An applicant may demonstrate
156 that he or she has expended sufficient capital to make

157 substantial progress in opening a dental practice that is
158 capable of serving at least 1,200 patients by documenting
159 contracts for the purchase or lease of a practice location and
160 providing executed obligations for the purchase or other
161 acquisition of at least 30 percent of the value of equipment or
162 supplies necessary to operate a dental practice. The department
163 may limit the number of applicants selected and shall give
164 priority to those applicants practicing in the areas receiving
165 higher rankings pursuant to subsection (11). The department may
166 establish additional criteria for selection which recognize an
167 applicant's active engagement with and commitment to the
168 community providing a local match.
169 (b) A process to verify that funds withdrawn from a dental
170 care access account have been used solely for the purposes
171 described in subsection (4).
172 (11) The Department of Economic Opportunity shall rank the
173 dental health professional shortage areas and medically
174 underserved areas of the state based on the extent to which
175 limited access to dental care is impeding the area's economic
176 development, with a higher ranking indicating a greater
177 impediment to development.
178 (12)(a) By January 1 of each year, beginning in 2018, the
179 department shall issue a report to the Governor, the President
180 of the Senate, and the Speaker of the House of Representatives,
181 which must include:
182 1. The number of patients served by dentists receiving

183 funding under this section.
184 2. The number of Medicaid recipients served by dentists
185 receiving funding under this section.
186 3. The average number of hours worked and patients served
187 in a week by dentists receiving funding under this section.
188 4. The number of dentists in each dental health
189 professional shortage area or medically underserved area
190 receiving funding under this section.
191 5. The amount and source of local matching funds received
192 by the department.
193 6. The amount of state funds awarded to dentists under
194 this section.
195 7. A complete accounting of the use of funds, by
196 categories identified by the department, including, but not
197 limited to, loans, supplies, equipment, rental property
198 payments, real property purchases, and salary and wages.
199 (b) The department shall adopt rules to require dentists
200 to report information to the department which is necessary for
201 the department to fulfill its reporting requirement under this
202 subsection.
203 Section 2. This act shall take effect July 1, 2016.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Appropriations Committee
2 Representative Cummings offered the following:
3
4 **Amendment (with title amendment)**
5 Between lines 202 and 203, insert:
6 Section 2. For the 2016-2017 fiscal year, 1 full-time equivalent
7 position, with associated salary rate of 46,381 is authorized
8 and the sums of $90,542 in recurring funds and $19,766 in
9 nonrecurring funds to administer the program and $1,000,000 in
10 recurring funds to allocate to dental care access accounts from
11 the General Revenue Fund are hereby appropriated to the
12 Department of Health for the purpose of implementing the
13 requirements of the act.
14
15 ----------
16 **T I T L E A M E N D M E N T**
17 Remove line 39 and insert:

18 reporting; providing an appropriation; providing an effective
19 date.

CS/HB 221

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 221 Out-of-Network Health Insurance Coverage
SPONSOR(S): Insurance & Banking Subcommittee, Trujillo and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1442

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Peterson	Luczynski
2) Appropriations Committee		White CCW	Leznoff
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A Preferred Provider Organization (PPO) is a health plan that contracts with providers to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing amounts if covered services are obtained from network (participating, preferred, or network) providers. However, if a member chooses to obtain services from an out-of-network (nonparticipating) provider, the member can be billed for the difference between the provider's charges and the PPO's approved reimbursement. In an Exclusive Provider Organization (EPO) arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a nonparticipating provider the lesser of the provider's charges; the usual and customary rate for provider charges in the community; or the rate agreed to between the provider and the HMO. The nonparticipating provider may not collect additional reimbursement from the subscriber. In other words, the provider cannot balance bill the patient. The law does not currently prohibit providers who are not part of a preferred or exclusive provider network from balance billing patients for emergency or nonemergency services.

The bill prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. The bill establishes standards for determining reimbursement to the providers; authorizes the providers to initiate arbitration to determine additional reimbursement; requires the Department of Financial Services to maintain a list of qualified arbitrators and collect decisions; and provides requirements for the arbitration process, including responsibility for attorney fees and additional costs.

Finally, the bill: requires all PPOs to publish a list of their network providers on their websites, and to update the list monthly; requires all PPOs to give subscribers notice regarding the potential for balance billing when using out-of-network providers; subjects certain facilities and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing; and requires hospitals to publish information on their websites regarding their contracts with plans and providers of hospital-based services.

The bill has an indeterminate insignificant fiscal impact on the state and local governments.

The bill is effective October 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Managed Care Organizations

Types[1]

Preferred Provider Organization[2]
A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. An insurer that offers a PPO plan must make its current list of preferred providers available to its members.

Exclusive Provider Organization[3]
In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions.

Health Maintenance Organization[4]
An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.[5]

Regulation
The Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations, and other risk-bearing entities.[6] To operate in Florida, an HMO must obtain a certificate of authority from OIR.[7] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA pursuant to part III of ch. 641, F.S.[8]

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[1] *See generally* FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers, available at*: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/chmo.shtml (last visited Jan. 16, 2016).
[2] *See generally* s. 627.6471, F.S.
[3] *See generally* s. 627.6472, F.S.
[4] *See generally* part I of chapter 641, F.S.
[5] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a nonparticipating provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a nonparticipating provider.
[6] s. 20.121(3)(a)1., F.S.
[7] ss. 641.21(1) and. 641.49, F.S.
[8] ss. 641.21(1) and 641.48, F.S.

As part of the certification process used by AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[9]

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.[10]

Balance Billing[11]

Balance billing describes the situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the managed care organization paid on the claim. Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured paid the provider directly then sought reimbursement from the insurer. The insurer reimbursed, minus any cost sharing, up to the policy amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed.

Today most people with private insurance are covered by a managed care organization (MCO). Members must utilize the services of network providers to minimize out-of-pocket expenses. Typically, contracts between network providers include a "hold harmless" provision that protects members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a member beyond payment of applicable cost-sharing requirements, such as copayments, co-insurance, or deductibles.

A member may choose to seek care from a nonparticipating provider, for example from a specialist regarded as an expert in the field. A member may utilize out-of-network providers unknowingly while receiving care at a network hospital. While radiologists, anesthesiologists, pathologists, and increasingly emergency room physicians are hospital-based physicians, generally they are not hospital employees and may or may not contract with the same MCOs as the hospital. Likewise, a member may receive—and be billed for—services from a nonparticipating provider if the member's network physician consults with a nonparticipating specialist. This is generally referred to as "surprise billing." Finally, a member may receive out-of-network care from an out-of-network hospital as a result of an emergency transport.

An analysis conducted for the California HealthCare Foundation in 2006 of 1.2 million residents with employer-sponsored commercial (private) insurance found that almost 11 percent of those studied used out-of-network services at some point during the year. Most out-of-network utilization occurred as a result of a hospital admission, or an emergency department visit without admission. The average balance bill (across facilities, physicians, and other professional providers) was $1,289 in addition to the average patient cost-sharing amount of $433. The average balance bill for an inpatient admission averaged $6,812.[12]

According to a recent study conducted by the Kaiser Family Foundation and the New York Times, one in five (20 percent) of U.S. adults ages 18 – 64 *with insurance* report that they or someone in their household had problems paying a medical bill.[13] Of those, 75 percent say that the amount they had to

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[9] s. 641.495, F.S.
[10] s. 627.642, F.S.
[11] *See generally* CALIFORNIA HEALTHCARE FOUNDATION, *Unexpected Charges: What States Are Doing About Balance Billing* (April 2009), *available at* http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing (last visited Jan. 15, 2015).
[12] *Id.* at 4.
[13] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey,* Jan. 2016, at 1, *available at* http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/?utm_campaign=KFF%3A+2015+December+KFF+NY+Times+Medical+Debt&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-811G5oUaaAYr6uoeChnST13pyBbh3AXerbZqYy-sz9DT7TXvXwILDCoV9tYHvY36G5i73DlRghX6-J-AViQkuqXJhEnA&_hsmi=24816172.

pay for insurance copays, deductibles, or coinsurance was more than they could afford.[14] Another 32 percent say they received care from an out-of-network provider that their insurance did not cover. For many, the bills were a surprise. Sixty-nine percent indicated that they were unaware that the provider was not in their plan's network when they received the care.[15]

Current Prohibitions on Balance Billing

Currently, balance billing is prohibited for services provided under Medicaid;[16] workers' compensation insurance;[17] by an exclusive provider who is part of an EPO; [18] or by a provider who is under contract with a prepaid limited service organization.[19] In addition, the law provides that an HMO is liable to pay, and may not balance bill, for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[20] However, the statute further qualifies the prohibition by saying that an HMO is liable for services rendered if the provider obtains authorization from the HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization. [21,22]

Florida Insurance Consumer Advocate

On October 15, 2015, the Insurance Consumer Advocate held a forum to solicit testimony from stakeholders on the issue of balance billing. On November 18, 2015, the Consumer Advocate presented her recommendations for legislation to implement the findings of the forum to the House Subcommittee on Insurance & Banking:[23]

- Hold consumers harmless (prohibit balance billing") in emergency and "surprise billing" situations.
- Establish an alternative dispute resolution process to allow nonparticipating providers to challenge the amount of payment received from an insurer.
- Conduct a study of network adequacy requirements applicable to insurers.
- Require disclosure in all contracts for services involving network providers of the potential billing consequences of using out-of-network providers.
- Require insurers to update their provider directories on a timely basis.
- Require hospitals to make data available regarding hospital-based providers who are not in the network.

Effect of Changes Related to Balance Billing

The bill prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. The effect

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[14] *Id.* at 11.
[15] *Id.* at 12.
[16] s. 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing. (E-mail from Josh Spagnola, Legislative Affairs Director, Florida Agency for Health Care Administration, excerpting relevant provisions from the Handbook and the CORE contract (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[17] s. 440.13(13)(a), F.S.
[18] s. 627.6472(4)(e), F.S.
[19] s. 636.035(3) - (4), F.S.
[20] ss. 641.315(1) and 641.3154(1), F.S.
[21] *But see Joseph L. Riley Anesthesia Associates v. Stein*, 27 So. 3d 140, 145 (Fla. 5th DCA 2010). The Fifth DCA has held that an authorization issued to a contract provider for services (surgery) in a hospital is deemed an authorization for a hospital-based provider of medically necessary services (anesthesia) that are provided under an exclusive contract without regard for the existence of a contract with the HMO. In other words, if the main service is authorized, related services provided under an exclusive contract are deemed authorized and balance billing is prohibited. *See also* Rule 69O-191.049, F.A.C. (prohibiting hospital-based physicians from balance billing an HMO subscriber who receives covered services in a network hospital.)
[22] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited Jan. 17, 2016).
[23] INSURANCE CONSUMER ADVOCATE, *Recommendations for a Balanced Approach to Unexpected Medical Expenses, Florida House of Representatives Insurance and Banking Subcommittee* (Nov. 18, 2015) (on file with the Insurance & Banking Subcommittee).

is to eliminate balance billing in the emergency and "surprise" billing scenarios. This would mean consumers who have PPO or EPO coverage would only be responsible for billing differences in circumstances where they knowingly opted to receive out-of-network care. Under the bill, the protections for members of HMOs would remain unchanged.

Current Situation

Access to Emergency Services and Care

Hospital 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. 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 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.[24] A hospital that violates EMTALA is subject to civil monetary penalty,[25] termination of its Medicare agreement,[26] or civil suit by a patient who suffers personal harm.[27] EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[28] The law requires AHCA 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 expressly prohibited from basing 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 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.

Prehospital Care

The Emergency Medical Transportation Services Act[29] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health (DOH). Ambulance services operate pursuant to a license issued by the DOH and a certificate of public convenience and necessity issued from each county in which the provider operates.[30] A licensee may not deny a person needed prehospital treatment or transport for

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[24] 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. 16, 2016).
[25] 42 U.S.C. § 1395dd(d)(1).
[26] 42 C.F.R. § 489.24(f).
[27] 42 U.S.C. § 1395dd(d)(2).
[28] *See* s. 395.1041, F.S.
[29] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.).
[30] s. 401.25(2)(d), F.S.

an emergency medical condition.[31] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[32]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers a type and level of care appropriate to the patient's medical condition,[33] with separate protocols required for stroke patients.[34] Trauma alert patients are an exception to the general requirement and are required to be transported to an approved trauma center.[35]

State law establishes the provision of ambulance services as a core function of county government.[36] Counties may provide the service directly, under contract with one or more private or municipal providers, or both. In 2015, 61 counties and 97 municipalities were licensed to provide emergency medical services.[37] This represents more than half of all licensed providers.

Payment for Emergency Services and Care

Florida Law

A PPO must charge a member the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider.[38]

An EPO plan must ensure that emergency care is available 24 hours a day and 7 days a week. Insurers issuing exclusive provider contracts must pay for services provided by non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.[39]

An HMO must provide coverage without prior authorization for prehospital transport or treatment or for emergency services and care[40] that is rendered by either a participating or nonparticipating provider.[41] An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider. [42]

The law requires HMOs to pay nonparticipating providers specified minimum reimbursement for emergency services. Specifically, HMOs must reimburse providers the lesser of:[43]

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community; or
- The charge mutually agreed to by the HMO and the provider.

Reimbursement is net of any applicable copayment.

Patient Protection and Affordable Care Act (PPACA)

PPACA was signed into law on March 23, 2010.[44] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and

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[31] s. 401.45, F.S.
[32] s. 401.411, F.S.
[33] Rule 64J-1.004()(a), F.A.C.
[34] s. 395.3041(3), F.S.
[35] s. 395.4045, F.S.
[36] *See* s. 125.01(1)(e), F.S.; *see also* s. 155.22, F.S.
[37] Florida Department of Health, *EMS Provider Type Reports* (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[38] s. 627.6405(4), F.S.
[39] s. 627.6472, F.S.
[40] "Emergency services and care" include the medical screening, examination, and evaluation to determine whether an emergency medical condition exists and the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition. s. 641.47(8), F.S.
[41] ss. 641.31(12) and 641.513(1)(a), F.S.
[42] s. 641.31097(4), F.S.
[43] s. 641.513(5), F.S.

employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, coverage for adult dependents, and other requirements.[45]

PPACA requires that coverage for emergency services must be provided without prior authorization and regardless of whether the provider is a network provider. Services provided by out-of-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. In addition, plans must reimburse out-of-network providers the greater of:

- The median in-network rate;
- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate. [46]

Grandfathered health plans are exempt from these requirements.[47] PPACA does not prohibit balance billing. A guidance document from the U.S. Department of Labor has characterized the requirements as "set[ting] forth minimum payment standards...to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient." The guidance further states that the minimum payment requirements do not apply if state law prohibits balance billing or the plan is contractually responsible for payment.[48]

Effect of Changes Related to Payment for Emergency Services and Care and Nonemergency Services and Care

The bill defines "emergency services" as the services and care to treat an "emergency medical condition," as that term is defined in s. 641.47, F.S., related to HMOs. The bill defines "nonemergency services" as the services and care to treat a condition other than an "emergency medical condition," as defined in s. 395.002, F.S. The definitions of "emergency medical condition" in both sections of existing law are substantially the same.

The bill creates a new section of law that establishes requirements for PPOs and EPOs related to coverage for emergency care. The requirements mirror federal law and are similar to state law applicable to HMOs. Specifically, the bill:

- Prohibits prior authorization;
- Requires coverage whether service is provided by a participating or nonparticipating provider; and
- Requires cost-sharing to be the same whether services are provided by a participating or nonparticipating provider.

The bill sets reimbursement to nonparticipating providers of both emergency and nonemergency services at:

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[44] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11th Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[45] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act. 42 U.S.C. 300gg et seq.
[46] 45 C.F.R. s. 147.138(b).
[47] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. (PPACA § 1251; 42 U.S.C. § 18011; 45 C.F.R. § 147.140).
[48] U.S. Dept. of Labor, Employee Benefits Security Administration, *FAQs About the Affordable Care Act Implementation Part I*, http://www.dol.gov/ebsa/faqs/faq-aca.html (last visited Jan. 16, 2015).

- The billed amount;
- An amount that is reasonable reimbursement for the services and care; or
- A charge mutually agreed to by the insurer and the nonparticipating provider.

Reimbursement is net of any applicable copayment or coinsurance.

A provider may dispute payment that the provider believes is inadequate by sending the insurer a final offer of reimbursement within 60 days after receipt of payment. The insurer then has 30 days to respond, whether by accepting the amount or countering with an alternative final offer of reimbursement. If the parties still disagree, the provider may initiate binding arbitration within 30 days of the insurer's final offer. The Department of Financial Services (DFS) has responsibility to maintain the list of eligible arbitrators, who must meet specified qualifications, and to provide the parties with a list of five from which they must choose if they fail to agree on a selection from the broader list. The arbitrator receives the final reimbursement offers that have been made by each party and, in rendering his or her decision, is limited to choosing one or the other amount. The arbitrator provides the DFS a copy of the decision, which then is available for consideration in future arbitration actions on similar claims.

The arbitration shall consist only of a review of the final offers and any of the permitted documentation submitted by the parties. In making his or her determination, the arbitrator must consider such documentation, which supports one or more of the criteria set forth in the bill related to specified factors, including: patient characteristics; the provider's qualifications; provider charges; other reimbursement methodologies; and prior arbitration decisions. The bill specifies maximum timeframes for each of the steps in the arbitration process, which results in an action that may take not more than 215 days. The cost of the arbitration[49] is split between the parties and each party is responsible for his or her own attorney fees.

Miscellaneous Changes

Finally, the bill:

- Requires all PPOs to publish the list of their network providers, including specified demographic information, on their websites, and to update the list with reported changes monthly.
- Requires all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing.
- Subjects hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing.
- Requires hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 2: Amends s. 395.301, F.S., relating to itemized patient bill; form and content prescribed by the agency; patient admission status notification.
Section 3: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 4: Creates s. 627.64194, F.S., relating to coverage requirements for services provided by nonparticipating providers.
Section 5: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.
Section 6: Provides an effective date of October 1, 2016.

[49] According to research conducted by the Office of the Insurance Consumer Advocate, the estimated cost for an arbitration ranges from a low of $325 to a high of $1,500. Emails from Jennifer Ferris, Chief Counsel, Florida Department of Financial Services, Office of the Insurance Consumer Advocate, RE: Arbitration cost (Jan. 20 & 22, 2016) (on file with the House Insurance & Banking Subcommittee).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers may experience a negative fiscal impact from the provisions that prohibit balance billing if these providers currently rely on that practice and do not receive comparable reimbursement as a result of payment received under the standard for reimbursement and arbitration procedure provided in the bill.

The bill will have a positive fiscal impact on consumers due to the prohibition on balance billing. The magnitude of the impact, however, is not known because no data currently exist to quantify the amount collected as a result of the practice.

D. FISCAL COMMENTS:

The Department of Management Services indicates that there is no impact to state group health plan members.[50] There is an indeterminate but likely insignificant negative fiscal impact on the Department of Financial Services associated with administration of the arbitration requirement.

The bill currently includes emergency transportation and ambulance services "to the extent permitted by applicable state and federal law" within the definition of "emergency services." The scope of "emergency transportation and ambulance services" is not clear, as these terms are not specifically defined in Florida statutes; however, they may contemplate covering ground ambulance services, which currently are provided in many communities by city or county government. If a local government currently relies on balance billing to fund an ambulance program, then the bill could cause the local government to suspend the program; impose a general tax increase to fund services; or impose higher user fees that may be paid, if they are collected, from individuals without health insurance (including Medicaid and Medicare).

[50] February 4, 2016, Email from Department of Management Services staff on file with the Appropriations Committee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   The Supremacy Clause of the U.S. Constitution preempts state laws that impermissibly interfere with federal law. Preemption can be express or implied. When Congress chooses to expressly preempt state law, the only question for courts becomes determining whether the challenged state law is one that the federal law is intended to preempt. Implied preemption occurs either as a result of field preemption or conflict preemption. Federal law "occupies the field" when there is "no room" left for state regulation. Conflict preemption occurs where "compliance with both federal and state regulations is a physical impossibility."

   The Airline Deregulation Act of 1978 was enacted by Congress to encourage, develop, and attain an air transportation system which relies on competitive market forces to determine the quality, variety, and price of air services, among other purposes. By its terms, the act preempts the authority of a state "to enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." The bill prohibits nonparticipating providers from balance billing a patient for emergency services. "Emergency services" is defined to include emergency transportation and ambulance services, "to the extent permitted by applicable state and federal law." The bill further establishes a payment methodology to be used in determining the amount of payment for covered services provided by noncontract providers. This does not itself establish a payment rate, but relates to rate setting. The language in the bill is unclear regarding its intended scope, i.e., whether it is intended to include air ambulance services or whether the phrase "to the extent permitted by applicable state and federal law" is intended to acknowledge federal preemption under the Airline Deregulation Act of 1978. If not, the application of the bill to air ambulance providers may be preempted by federal law.

3. RULE-MAKING AUTHORITY:

   None.

4. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 19, 2016, the Insurance & Banking Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all:

- Removed the provisions in the bill that revise the methodology in current law used by HMOs to reimburse nonparticipating providers of emergency services and care.
- Added definitions of "emergency services," "nonemergency services," "facility," and "nonparticipating provider."
- Changed the methodology for determining reimbursement to nonparticipating providers of emergency and nonemergency services to:
  - The billed amount;

    - An amount that is reasonable reimbursement for the services and care; or
    - A charge mutually agreed to by the insurer and the nonparticipating providers.
- Prohibits balance billing for nonemergency services that are provided by a nonparticipating provider in a network facility where the patient had no ability and opportunity to choose a participating provider.
- Authorized nonparticipating providers of emergency and nonemergency services to initiate arbitration to determine additional reimbursement. In rendering his or her decision, the arbitrator must consider any documentation submitted by either the insurer or the provider relevant to: specified factors about the patient; the provider's qualifications; other reimbursement methodologies; and prior arbitration decisions.
- Provided that the arbitrator's decision is the amount contained in the final settlement offer from either the provider or the insurer.
- Required the DFS to develop and maintain the list of qualified arbitrators.
- Required all PPOs to publish the list of network providers, including specified demographic information, on their websites, and to update the list with reported changes monthly.
- Required all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing.
- Subjected certain facilities and providers subject to disciplinary action for violations of the prohibition on balance billing.
- Required hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

This analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.

1 A bill to be entitled
2 An act relating to out-of-network health insurance
3 coverage; amending s. 395.003, F.S.; requiring
4 hospitals, ambulatory surgical centers, specialty
5 hospitals, and urgent care centers to comply with
6 certain provisions as a condition of licensure;
7 amending s. 395.301, F.S.; requiring a hospital to
8 post on its website certain information regarding its
9 contracts with health insurers, health maintenance
10 organizations, and health care practitioners and
11 practice groups and specified notice to patients and
12 prospective patients; amending s. 456.072, F.S.;
13 adding a ground for discipline of referring health
14 care providers by the Department of Health; creating
15 s. 627.64194, F.S.; defining terms; specifying
16 requirements for coverage provided by an insurer for
17 emergency services; providing that an insurer is
18 solely liable for payment of certain fees to a
19 nonparticipating provider; providing limitations and
20 requirements for reimbursements by an insurer to a
21 nonparticipating provider; authorizing a
22 nonparticipating provider or insurer to initiate
23 arbitration to determine additional reimbursement;
24 requiring the Department of Financial Services to
25 publish a list of approved arbitrators; specifying
26 timeframes and the process for choosing an arbitrator;

27 providing requirements for the arbitration process,
28 including responsibility for attorney fees and
29 additional costs; amending s. 627.6471, F.S.;
30 requiring an insurer that issues a health insurance
31 policy including coverage for preferred provider
32 services to post certain information about preferred
33 providers, preferred provider facilities, and health
34 care providers in the preferred provider network on
35 its website; requiring a specified notice to be
36 included in such policies; providing an effective
37 date.
38
39 Be It Enacted by the Legislature of the State of Florida:
40
41 Section 1. Paragraph (d) is added to subsection (5) of
42 section 395.003, Florida Statutes, to read:
43 395.003 Licensure; denial, suspension, and revocation.—
44 (5)
45 (d) A hospital, ambulatory surgical center, specialty
46 hospital, or urgent care center shall comply with ss. 627.64194
47 and 641.513 as a condition of licensure.
48 Section 2. Subsection (13) is added to section 395.301,
49 Florida Statutes, to read:
50 395.301 Itemized patient bill; form and content prescribed
51 by the agency; patient admission status notification.—
52 (13) Each hospital shall post on its website:

53 (a) The names and hyperlinks for direct access to the
54 websites of all health insurers and health maintenance
55 organizations with which the hospital contracts as a network
56 provider or participating provider.
57 (b) A statement that:
58 1. Services provided in the hospital by health care
59 practitioners may not be included in the hospital's charges.
60 2. Health care practitioners who provide services in the
61 hospital may or may not participate with the same health
62 insurers and health maintenance organizations with which the
63 hospital contracts.
64 3. Prospective patients should contact the health care
65 practitioner arranging for the services to determine the health
66 care plans in which the health care practitioner participates.
67 (c) As applicable, the names, mailing addresses, and
68 telephone numbers of the health care practitioners and practice
69 groups under contract with the hospital to provide services in
70 the hospital and instructions on how to contact such
71 practitioners and practice groups to determine the health
72 insurers and health maintenance organizations with which the
73 hospital contracts as a network provider or participating
74 provider.
75 Section 3. Paragraph (oo) is added to subsection (1) of
76 section 456.072, Florida Statutes, to read:
77 456.072 Grounds for discipline; penalties; enforcement.—

78 (1) The following acts shall constitute grounds for which
79 the disciplinary actions specified in subsection (2) may be
80 taken:
81 (oo) Failing to comply with s. 627.64194 or s. 641.513
82 with such frequency as to constitute a general business
83 practice.
84 Section 4. Section 627.64194, Florida Statutes, is created
85 to read:
86 627.64194 Coverage requirements for services provided by
87 nonparticipating providers.—
88 (1) As used in this section, the term:
89 (a) "Emergency services" means the services and care to
90 treat an emergency medical condition, as defined in s. 395.002.
91 The term "emergency services" includes emergency transportation
92 and ambulance services to the extent permitted by applicable
93 state and federal law.
94 (b) "Facility" means a licensed facility, as defined in s.
95 395.002, or an urgent care center, as defined in s. 395.002.
96 (c) "Nonemergency services" means the services and care to
97 treat a condition other than an emergency medical condition, as
98 defined in s. 395.002.
99 (d) "Nonparticipating provider" means a provider that is
100 not a preferred provider, as defined in s. 627.6471, or an
101 exclusive provider, as defined in s. 627.6472.

102 (e) "Participating provider" means a preferred provider,
103 as defined in s. 627.6471, or an exclusive provider, as defined
104 in s. 627.6472.
105 (2) An insurer is solely liable for payment of fees to a
106 nonparticipating provider of emergency services and an insured
107 is not liable for payment of fees, other than applicable
108 copayments and deductibles, to a nonparticipating provider of
109 emergency services. An insurer must provide coverage for
110 emergency services that:
111 (a) May not require prior authorization.
112 (b) Must be provided regardless of whether the service is
113 furnished by a participating or nonparticipating provider.
114 (c) May impose a coinsurance amount, copayment, or
115 limitation of benefits requirement for a nonparticipating
116 provider only if the same requirement applies to a participating
117 provider.
118 (3) An insurer is solely liable for payment of fees to a
119 nonparticipating provider of nonemergency services and an
120 insured is not liable for payment of fees, other than applicable
121 copayments and deductibles, to a nonparticipating provider of
122 nonemergency services that are:
123 (a) Provided in a facility that has a contract with the
124 insurer.
125 (b) Provided under circumstances in which the insured does
126 not have the ability and opportunity to choose a participating
127 provider at the facility.

128 (4) An insurer must reimburse a nonparticipating provider
129 of emergency services or nonemergency services within the
130 applicable timeframe provided in s. 627.6131:
131 (a) The billed amount;
132 (b) An amount that is a reasonable reimbursement for the
133 services and care rendered; or
134 (c) A charge mutually agreed to by the insurer and the
135 nonparticipating provider.
136 (5) A nonparticipating provider of emergency services or
137 nonemergency services may not be reimbursed an amount greater
138 than that provided in subsection (4) or subsection (6) by the
139 insurer and may not collect or attempt to collect from the
140 patient, directly or indirectly, any excess amount.
141 (6)(a) If an insured has assigned his or her benefit of
142 payment to the nonparticipating provider, the nonparticipating
143 provider may, within 60 days after receipt of the reimbursement
144 provided in subsection (4), request additional reimbursement by
145 making a final reimbursement offer to the insurer. Within 30
146 days after receipt of the nonparticipating provider's final
147 reimbursement offer, the insurer shall notify the
148 nonparticipating provider of its final reimbursement offer. The
149 nonparticipating provider may initiate binding arbitration
150 within 30 days after receipt of the insurer's final
151 reimbursement offer by notifying the insurer and the department.
152 The notice of initiation of binding arbitration shall include
153 the final reimbursement offers from the nonparticipating

154 provider and the insurer. The parties may agree to resolve
155 multiple claims for additional reimbursement.
156 (b) The department shall publish a list of arbitrators
157 that it has approved to provide binding arbitration. Approved
158 arbitrators shall be trained by the American Arbitration
159 Association or the American Health Lawyers Association. The
160 parties must agree and notify the department of their choice of
161 an arbitrator from the list of approved arbitrators within 10
162 business days after issuance of the notice of initiation of
163 binding arbitration. If the parties cannot reach an agreement,
164 the nonparticipating provider shall, within 15 business days
165 after receiving the notice of initiation of binding arbitration,
166 request from the department the names of five approved
167 arbitrators. The insurer and the nonparticipating provider may
168 each veto two of the arbitrators. The nonparticipating provider
169 shall be the first party to veto two of the arbitrators and,
170 within 5 business days after receiving the names of the five
171 arbitrators, shall notify the insurer and the department of the
172 names of the two arbitrators it has vetoed. After receiving the
173 notice of veto, the insurer shall have 5 business days to notify
174 the nonparticipating provider and the department of the names of
175 the two arbitrators it has vetoed. The arbitrator remaining
176 after both parties have submitted their vetoes shall be the
177 chosen arbitrator.
178 (c) When making a determination of whether a
179 nonparticipating provider shall receive additional reimbursement

180 pursuant to this subsection, the parties may provide and the
181 arbitrator shall consider documentation of:
182 1. Individual patient characteristics.
183 2. The level of training, education, and experience of the
184 nonparticipating provider.
185 3. The nonparticipating provider's usual and customary
186 charge for similar or comparable services provided out-of-
187 network with respect to any health care plan.
188 4. A participating provider's contracted rate of payment
189 for similar or comparable services in the same geographic area.
190 5. The aggregate provider charge, as defined by a public
191 independent database of charges, for similar or comparable
192 services in the same geographic area.
193 6. A percentage of the Medicare allowable rate for similar
194 or comparable services in the same geographic area.
195 7. The usual and customary reimbursement by an insurer for
196 similar or comparable services in the same geographic area.
197 8. The nonparticipating provider's billed charges for the
198 services provided.
199 9. The circumstances and complexity of the particular
200 case, including the time and location of the service provided.
201 10. Discounts or rebates applied by the nonparticipating
202 provider to charges for similar or comparable services billed to
203 persons who are uninsured, indigent, or experiencing a financial
204 hardship.

205 11. Previous arbitration decisions made under this
206 subsection for similar or comparable services provided under
207 similar or comparable circumstances and characteristics.
208 (d) The arbitration shall consist only of a review of the
209 final reimbursement offer submitted by each party pursuant to
210 paragraph (a) and any documentation submitted pursuant to
211 paragraph (c). The arbitrator's decision shall be one of the two
212 amounts that were submitted as final reimbursement offers
213 pursuant to paragraph (a).
214 (e) The arbitrator shall render a written decision within
215 60 days after being named the chosen arbitrator and file the
216 decision with the department. The parties shall be bound by the
217 arbitrator's decision. The cost of arbitration shall be
218 reasonable and shall be equally shared by the parties. Each
219 party is responsible for his or her own attorney fees and
220 additional costs.
221 Section 5. Subsection (2) of section 627.6471, Florida
222 Statutes, is amended, and subsection (7) is added to that
223 section, to read:
224 627.6471 Contracts for reduced rates of payment;
225 limitations; coinsurance and deductibles.—
226 (2) Any insurer issuing a policy of health insurance in
227 this state, which insurance includes coverage for the services
228 of a preferred provider, must provide each policyholder and
229 certificateholder with a current list of preferred providers and
230 must make the list available on its website. The list must

231 include, when applicable and reported, organized by specialty:
232 the names, addresses, and telephone numbers of all preferred
233 providers and, for physicians, their board certifications,
234 languages spoken, and facility affiliations; and the names,
235 addresses, and telephone numbers of all preferred provider
236 facilities. Information posted on the insurer's website must be
237 updated each calendar month and include additions or
238 terminations of preferred providers, preferred provider
239 facilities, and health care providers in the preferred provider
240 network or changes in a health care provider's facility
241 affiliations ~~must make the list available for public inspection~~
242 ~~during regular business hours at the principal office of the~~
243 ~~insurer within the state~~.
244 (7) Each policy issued under this section must include the
245 following disclosure: "WARNING: LIMITED BENEFITS WILL BE PAID
246 WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware
247 that when you elect to use the services of a nonparticipating
248 provider for a covered nonemergency service, benefit payments to
249 the provider are not based on the amount the provider charges.
250 The basis of the payment will be determined according to your
251 policy's out-of-network reimbursement benefit. Nonparticipating
252 providers may bill insureds for any difference in the amount.
253 YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR
254 COPAYMENT. Participating providers have agreed to accept
255 discounted payments for services with no additional billing to
256 you other than coinsurance and deductible amounts. You may

257 obtain further information about the providers who have
258 contracted with your insurance plan by consulting your insurer's
259 website or contacting your insurer or agent directly."
260 Section 6. This act shall take effect October 1, 2016.

HB 301

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 301 Property Prepared for Tax-Exempt Use
SPONSOR(S): Burton and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 842

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Tax Committee	13 Y, 1 N	Dugan	Langston
2) Local & Federal Affairs Committee	16 Y, 0 N	Monroe	Kiner
3) Appropriations Committee		Hawkins	Leznoff

SUMMARY ANALYSIS

Current law permits an ad valorem tax exemption for certain property used predominately for non-profit educational, literary, scientific, religious or charitable purposes, subject to criteria established by statute. Additionally, property used for a house of worship, affordable housing, or educational purposes may be exempt prior to actual exempt use if the organization has taken affirmative steps to prepare the property for the specified exempt use.

The bill expands the "affirmative steps" ad valorem exemption to property owned by an exempt organization and used for literary, scientific, or charitable purpose. Similar to current law, the exempt organization must take "affirmative steps" to prepare the property for the specified exempt purpose. Except for property being prepared for use as a house of public worship, if the property is not in actual use for an exempt purpose within five years, the property owner must pay back taxes owed plus 15 percent interest. Further, a tax lien may be placed on such property for purposes of collecting these taxes unless the property owner demonstrates he or she is continuing to take affirmative steps, in which case the property owner may continue to receive the exemption.

The bill has an effective date of July 1, 2016 and will first affect property taxes levied for the 2017-2018 fiscal year.

The Revenue Estimating Conference determined that the bill will have a negative annual impact on local government revenues of $1 million beginning in Fiscal Year 2017-2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The Florida Constitution requires that all property be assessed at just value for ad valorem tax purposes,[1] and it provides for specified assessment limitations, property classifications and exemptions.[2] After the property appraiser considers any assessment limitation or use classification affecting the just value of a property, an assessed value is produced. The assessed value is then reduced by any exemptions to produce the taxable value.[3] Such exemptions include, but are not limited to, exemptions for such portions of property used predominately for educational, literary, scientific, religious or charitable purposes.[4] The Legislature has fully implemented these constitutional exemptions and set forth the criteria used to determine whether property is entitled to an exemption for use as a charitable, religious, scientific, or literary purpose.[5] Specific provisions exist for property for hospitals, nursing homes, and homes for special services;[6] property used for religious purposes;[7] educational institutions[8] and charter schools;[9] labor organization property;[10] nonprofit community centers;[11] biblical history displays;[12] and affordable housing.[13]

Property Entitled to Charitable, Religious, Scientific, or Literary Exemptions

In determining whether the use of a property qualifies the property for an ad valorem tax exemption, the property appraiser must consider the nature and extent of the qualifying activity compared to other activities performed by the organization owning the property, and the availability of the property for use by other qualifying entities.[14] Only the portions of the property used predominantly for qualified purposes may be exempt from ad valorem taxation. If the property owned by an exempt organization is used exclusively for exempt purposes, it shall be totally exempt from ad valorem taxation.

Property used for a house of worship, affordable housing, or educational purposes may be exempt if the organization has taken affirmative steps to prepare the property for the specified exempt use. Statute defines "affirmative steps" to mean:

- environmental or land use permitting activities;
- creation of architectural or schematic drawings;
- land clearing or site preparation;
- construction or renovation activities; or
- other similar activities that demonstrate a commitment to the exempt use.[15]

If affordable housing is granted a charitable exemption while performing these affirmative steps, but transfers the property for purposes other than affordable housing, or if the property is not actually used

[1] Fla. Const., art. VII, s. 4.
[2] Fla. Const., art. VII, ss. 3, 4, and 6.
[3] s. 196.031, F.S.
[4] Fla. Const., art. VII, s. 3.
[5] ss. 196.195 and 196.196, F.S.
[6] s. 196.197, F.S.
[7] ss. 196.1975(3) and 196.196(3), F.S.
[8] s. 196.198, F.S.
[9] s. 196.1983, F.S.
[10] s. 196.1985, F.S.
[11] s. 196.1986, F.S.
[12] s. 196.1987, F.S.
[13] s. 196.196(5), F.S.
[14] s. 196.196(1)(a)-(b), F.S.
[15] ss. 196.196(3),(5) and 196.198, F.S.

as affordable housing within five years after the exemption is granted, then the property is subject to back taxes, 15 percent interest, and a penalty of 50 percent of the taxes owed.[16] The five year limitation may be extended if the holder of the exemption continues to take affirmative steps to develop the property for affordable housing.[17]

In 2004, a Florida court held that charitable organizations in Florida are not entitled to exemptions while affirmative steps are being taken.[18] The Second District Court of Appeals held that a charitable organization was not entitled to an exemption while it was constructing its headquarters even though it would be entitled to an exemption once the headquarters was completely built.[19]

Charitable Organizations

Under federal law, an organization may only be tax-exempt if it is organized and operated for exempt purposes, including charitable and religious purposes.[20] None of the organization's earnings may benefit any private shareholder or individual, and the organization may not attempt to influence legislation as a substantial part of its activities. Charitable purposes include relief of the poor, the distressed or the underprivileged, the advancement of religion, and lessening the burdens of government.

Florida law defines a charitable purpose as a function or service which is of such a community service that its discontinuance could legally result in the allocation of public funds for the continuance of the function or the service.[21]

Determining Profit vs. Non-Profit Status of an Entity

Current law outlines the statutory criteria that a property appraiser must consider in determining whether an applicant for a religious, literary, scientific, or charitable exemption is a nonprofit or profit-making venture.[22] When applying for an exemption, an applicant is required to provide the property appraiser with "such fiscal and other records showing in reasonable detail the financial condition, record of operations, and exempt and nonexempt uses of the property . . . for the immediately preceding fiscal year."[23]

The applicant must show that "no part of the subject property, or the proceeds of the sale, lease, or other disposition thereof, will inure to the benefit of its members, directors, or officers or any person or firm operating for profit or for a nonexempt purpose."[24]

Based on the information provided by the applicant, the property appraiser must use the specified statutory criteria to determine whether the applicant is a nonprofit or profit-making venture or if the property is used for a profit-making purpose.[25]

A religious, literary, scientific, or charitable exemption may not be granted until the property appraiser, or value adjustment board on appeal, determines the applicant to be nonprofit.[26]

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[16] s. 196.196(5), F.S.
[17] s. 196.196(5), F.S.
[18] *Smith v. Am. Lung Ass'n of Gulfcoast Florida*, 870 So. 2d 241 (Fla. 2d DCA 2004).
[19] *Id.*
[20] 26 U.S.C. § 501(c)(3).
[21] s. 196.012(7), F.S.
[22] s. 196.195, F.S.,
[23] s. 196.195(1), F.S.
[24] s. 196.195(3), F.S.
[25] s. 196.195(2)(a)-(e), F.S.
[26] s. 196.195(4), F.S.

Proposed Changes

The bill creates s. 196.1955, F.S., allowing property owned by an exempt organization to receive an ad valorem exemption for educational, literary, scientific, religious or charitable purpose if the property owner has taken "affirmative steps" to prepare the property for an exempt purpose. The bill consolidates the existing provisions allowing affordable housing, religious houses of worship, and educational property to receive the exemption while affirmative steps are being taken into one provision that would allow all educational, literary, scientific, religious or charitable property to use this exemption. Except for property being prepared for use as a house of public worship, if the property is not in actual use for an exempt purpose within five years, the property owner must pay back taxes owed plus 15 percent interest per annum. Further, a tax lien may be placed on such property for purposes of collecting these taxes unless the property owner is continuing to take affirmative steps, in which case the property owner may continue to receive the exemption. However, the lien provisions do not apply to property being prepared for use as a house of "public worship," which the bill defines as "religious worship services and activities that are incidental to religious worship services, such as educational activities, parking, recreation, partaking of meals, and fellowship."

The bill defines "affirmative steps," consistent with existing law, to be:

- environmental or land use permitting activities;
- creation of architectural or schematic drawings;
- land clearing or site preparation;
- construction or renovation activities; or
- other similar activities that demonstrate a commitment to prepare the property for an exempt use.

The bill clarifies that if an exemption is improperly granted as a result of a mistake by the property appraiser, the property owner does not owe interest.

The bill also makes technical and conforming changes to ss. 196.196 and 196.198, F.S.

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

B. SECTION DIRECTORY:

Section 1. Creates s. 196.1955, F.S., allowing property to be exempt from ad valorem taxation for certain purposes while the property owner is taking affirmative steps to put the property in use for such purpose. Provides for remedies if the property is not put to such use within five years.

Section 2. Conforms and makes technical corrections to s. 196.196, F.S., by deleting language made unnecessary by the creation of s. 196.1955, F.S., and renumbering certain subsections.

Section 3. Conforms and makes technical corrections to s. 196.198, F.S., by deleting language made unnecessary by the creation of s. 196.1955, F.S., and creating certain subsections and paragraphs.

Section 4. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   On January 13, 2016, the Revenue Estimating Conference determined that the bill will have a negative recurring impact on local government revenues of $1 million beginning in Fiscal Year 2017-18 ($0.4 million for school purposes and $0.6 million for non-school purposes), growing to negative $1.1 million in FY 2020-21. There is no cash impact in FY 2016-17 due to the effective date of the bill (property tax values are measured January 1).

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Exempt organizations will receive an ad valorem exemption while they are taking affirmative steps toward their exempt purpose. Such organizations will receive a tax benefit because they will not have to wait until the property is in actual use for educational, literary, scientific, religious or charitable purposes before receiving the exemption.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The county/municipality mandates provision of article VII, section 18(b) of the Florida Constitution may apply because this bill will reduce local government property tax revenues through a reduced tax base; however, an exemption may apply because the fiscal impact may be insignificant.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to property prepared for tax-exempt
3 use; creating s. 196.1955, F.S.; consolidating
4 provisions relating to obtaining an ad valorem
5 exemption for property owned by exempt organizations;
6 requiring the owner of an exempt organization to take
7 affirmative steps to demonstrate the property's exempt
8 use; authorizing the property appraiser to serve a
9 notice of tax lien on exempt property that is not in
10 actual exempt use after a specified time; providing
11 that the lien attaches to any property owned by the
12 organization identified in the notice of lien;
13 prohibiting a property appraiser from serving a notice
14 of tax lien on certain property being prepared for use
15 as a house of public worship; defining the terms
16 "charitable use," "affirmative steps," and "public
17 worship"; amending s. 196.196, F.S.; deleting
18 provisions relating to the exemption as it applies to
19 public worship and affordable housing and provisions
20 that have been moved to s. 196.1955, F.S.; amending s.
21 196.198, F.S.; deleting provisions that have been
22 moved to s. 196.1955, F.S., relating to property owned
23 by an educational institution and used for an
24 educational purpose; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:

27

28 Section 1. Section 196.1955, Florida Statutes, is created
29 to read:
30 196.1955 Preparing property for educational, literary,
31 scientific, religious, or charitable use.—
32 (1) Property owned by an exempt entity is used for an
33 exempt purpose if the owner has taken affirmative steps to
34 prepare the property for an exempt educational, literary,
35 scientific, religious, or charitable use and no portion of the
36 property is being used for a nonexempt purpose. The term
37 "charitable use" means, but is not limited to, providing
38 affordable housing to extremely-low-income, very-low-income,
39 low-income, or moderate-income persons and families as defined
40 in s. 420.0004. The term "affirmative steps" means environmental
41 or land use permitting activities, creation of architectural
42 plans or schematic drawings, land clearing or site preparation,
43 construction or renovation activities, or other similar
44 activities that demonstrate a commitment to preparing the
45 property for an exempt use.
46 (2)(a) If property owned by an organization that has been
47 granted an exemption under this section is transferred for a
48 purpose other than an exempt use or is not in actual exempt use
49 within 5 years after the date the organization is granted an
50 exemption, the property appraiser making such determination may
51 serve upon the organization that received the exemption a notice
52 of intent to record in the public records of the county a notice

53 of tax lien against any property owned by that organization in
54 that county, and such property must be identified in the notice
55 of tax lien. The organization owning such property is subject to
56 the taxes otherwise due as a result of the failure to use the
57 property in an exempt manner plus 15 percent interest per annum.
58 1. The lien, when filed, attaches to any property
59 identified in the notice of tax lien owned by the organization
60 that received the exemption. If the organization no longer owns
61 property in the county but owns property in any other county in
62 the state, the property appraiser shall record in each such
63 county a notice of tax lien identifying the property owned by
64 the organization in each respective county, which shall become a
65 lien against the identified property.
66 2. Before such lien may be filed, the organization so
67 notified must be given 30 days to pay the taxes and interest.
68 3. If an exemption is improperly granted as a result of a
69 clerical mistake or an omission by the property appraiser, the
70 organization improperly receiving the exemption may not be
71 assessed interest.
72 4. The 5-year limitation specified in this subsection may
73 be extended by the property appraiser if the organization
74 holding the exemption continues to take affirmative steps to
75 develop the property for the purposes specified in this section.
76 (b) This subsection does not apply to property being
77 prepared for use as a house of public worship. The term "public
78 worship" means religious worship services and activities that

79 are incidental to religious worship services, such as
80 educational activities, parking, recreation, partaking of meals,
81 and fellowship.
82 Section 2. Subsections (3), (4), and (5) of section
83 196.196, Florida Statutes, are amended to read:
84 196.196 Determining whether property is entitled to
85 charitable, religious, scientific, or literary exemption.—
86 ~~(3) Property owned by an exempt organization is used for a~~
87 ~~religious purpose if the institution has taken affirmative steps~~
88 ~~to prepare the property for use as a house of public worship.~~
89 ~~The term "affirmative steps" means environmental or land use~~
90 ~~permitting activities, creation of architectural plans or~~
91 ~~schematic drawings, land clearing or site preparation,~~
92 ~~construction or renovation activities, or other similar~~
93 ~~activities that demonstrate a commitment of the property to a~~
94 ~~religious use as a house of public worship. For purposes of this~~
95 ~~subsection, the term "public worship" means religious worship~~
96 ~~services and those other activities that are incidental to~~
97 ~~religious worship services, such as educational activities,~~
98 ~~parking, recreation, partaking of meals, and fellowship.~~
99 (3) ~~(4)~~ Except as otherwise provided in this section
100 ~~herein~~, property claimed as exempt for literary, scientific,
101 religious, or charitable purposes which is used for profitmaking
102 purposes is ~~shall be~~ subject to ad valorem taxation. Use of
103 property for functions not requiring a business or occupational
104 license conducted by the organization at its primary residence,

105 the revenue of which is used wholly for exempt purposes, is
106 ~~shall~~ not ~~be~~ considered profitmaking ~~profit making~~. In this
107 connection, the playing of bingo on such property is ~~shall~~ not
108 ~~be~~ considered as using such property in such a manner as would
109 impair its exempt status.
110 ~~(5)(a) Property owned by an exempt organization qualified~~
111 ~~as charitable under s. 501(c)(3) of the Internal Revenue Code is~~
112 ~~used for a charitable purpose if the organization has taken~~
113 ~~affirmative steps to prepare the property to provide affordable~~
114 ~~housing to persons or families that meet the extremely-low-~~
115 ~~income, very-low-income, low-income, or moderate-income limits,~~
116 ~~as specified in s. 420.0004. The term "affirmative steps" means~~
117 ~~environmental or land use permitting activities, creation of~~
118 ~~architectural plans or schematic drawings, land clearing or site~~
119 ~~preparation, construction or renovation activities, or other~~
120 ~~similar activities that demonstrate a commitment of the property~~
121 ~~to providing affordable housing.~~
122 ~~(b)1. If property owned by an organization granted an~~
123 ~~exemption under this subsection is transferred for a purpose~~
124 ~~other than directly providing affordable homeownership or rental~~
125 ~~housing to persons or families who meet the extremely-low-~~
126 ~~income, very-low-income, low-income, or moderate-income limits,~~
127 ~~as specified in s. 420.0004, or is not in actual use to provide~~
128 ~~such affordable housing within 5 years after the date the~~
129 ~~organization is granted the exemption, the property appraiser~~
130 ~~making such determination shall serve upon the organization that~~

131 ~~illegally or improperly received the exemption a notice of~~
132 ~~intent to record in the public records of the county a notice of~~
133 ~~tax lien against any property owned by that organization in the~~
134 ~~county, and such property shall be identified in the notice of~~
135 ~~tax lien. The organization owning such property is subject to~~
136 ~~the taxes otherwise due and owing as a result of the failure to~~
137 ~~use the property to provide affordable housing plus 15 percent~~
138 ~~interest per annum and a penalty of 50 percent of the taxes~~
139 ~~owed.~~
140 ~~2. Such lien, when filed, attaches to any property~~
141 ~~identified in the notice of tax lien owned by the organization~~
142 ~~that illegally or improperly received the exemption. If such~~
143 ~~organization no longer owns property in the county but owns~~
144 ~~property in any other county in the state, the property~~
145 ~~appraiser shall record in each such other county a notice of tax~~
146 ~~lien identifying the property owned by such organization in such~~
147 ~~county which shall become a lien against the identified~~
148 ~~property. Before any such lien may be filed, the organization so~~
149 ~~notified must be given 30 days to pay the taxes, penalties, and~~
150 ~~interest.~~
151 ~~3. If an exemption is improperly granted as a result of a~~
152 ~~clerical mistake or an omission by the property appraiser, the~~
153 ~~organization improperly receiving the exemption shall not be~~
154 ~~assessed a penalty or interest.~~
155 ~~4. The 5-year limitation specified in this subsection may~~
156 ~~be extended if the holder of the exemption continues to take~~

157 ~~affirmative steps to develop the property for the purposes~~
158 ~~specified in this subsection.~~
159 Section 3. Section 196.198, Florida Statutes, is amended
160 to read:
161 196.198 Educational property exemption.—
162 (1) Educational institutions within this state and their
163 property used by them or by any other exempt entity or
164 educational institution exclusively for educational purposes are
165 exempt from taxation.
166 (a) Sheltered workshops providing rehabilitation and
167 retraining of individuals who have disabilities and exempted by
168 a certificate under s. (d) of the federal Fair Labor Standards
169 Act of 1938, as amended, are declared wholly educational in
170 purpose and are exempt from certification, accreditation, and
171 membership requirements set forth in s. 196.012.
172 (b) Those portions of property of college fraternities and
173 sororities certified by the president of the college or
174 university to the appropriate property appraiser as being
175 essential to the educational process are exempt from ad valorem
176 taxation.
177 (c) The use of property by public fairs and expositions
178 chartered by chapter 616 is presumed to be an educational use of
179 such property and is exempt from ad valorem taxation to the
180 extent of such use.
181 (2) Property used exclusively for educational purposes
182 shall be deemed owned by an educational institution if the

183 entity owning 100 percent of the educational institution is
184 owned by the identical persons who own the property, or if the
185 entity owning 100 percent of the educational institution and the
186 entity owning the property are owned by the identical natural
187 persons.
188 (a) Land, buildings, and other improvements to real
189 property used exclusively for educational purposes shall be
190 deemed owned by an educational institution if the entity owning
191 100 percent of the land is a nonprofit entity and the land is
192 used, under a ground lease or other contractual arrangement, by
193 an educational institution that owns the buildings and other
194 improvements to the real property, is a nonprofit entity under
195 s. 501(c)(3) of the Internal Revenue Code, and provides
196 education limited to students in prekindergarten through grade
197 8.
198 (b) If legal title to property is held by a governmental
199 agency that leases the property to a lessee, the property shall
200 be deemed to be owned by the governmental agency and used
201 exclusively for educational purposes if the governmental agency
202 continues to use such property exclusively for educational
203 purposes pursuant to a sublease or other contractual agreement
204 with that lessee.
205 (c) If the title to land is held by the trustee of an
206 irrevocable inter vivos trust and if the trust grantor owns 100
207 percent of the entity that owns an educational institution that
208 is using the land exclusively for educational purposes, the land

209 is deemed to be property owned by the educational institution
210 for purposes of this exemption. ~~Property owned by an educational~~
211 ~~institution shall be deemed to be used for an educational~~
212 ~~purpose if the institution has taken affirmative steps to~~
213 ~~prepare the property for educational use. The term "affirmative~~
214 ~~steps" means environmental or land-use permitting activities,~~
215 ~~creation of architectural plans or schematic drawings, land~~
216 ~~clearing or site preparation, construction or renovation~~
217 ~~activities, or other similar activities that demonstrate~~
218 ~~commitment of the property to an educational use.~~
219 Section 4. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 445 Viatical Settlements
SPONSOR(S): Insurance & Banking Subcommittee; Stevenson and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 650

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	10 Y, 1 N, As CS	Bauer	Luczynski
2) Appropriations Committee		Keith	Leznoff
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

An *insurable interest* exists for purposes of life insurance when a policyholder has a reasonable expectation that he or she will benefit from the continued life and health of the insured person. In Florida, it is recognized that an individual has an insurable interest as to his or her own life, body, and health, and that other persons with a "love and affection" or pecuniary relationship to the insured (such as family members or a corporate employer) also have valid insurable interests. It has long been recognized in American jurisprudence that life insurance policies purchased without an insurable interest (i.e., on strangers) violate public policy, because they constitute a mere wager on human lives that creates a perverse desire for the early death of the insured. In some instances, life insurance policyholders may wish to sell their policies to third parties as a way to obtain cash for medical expenses or other needs. In these transactions, known as *viatical settlements*, companies called *viatical settlement providers* (VSPs) purchase the policy from the insured (*the viator*) for more than its cash surrender value, but less than the face value of the policy. In 1996, Florida established a regulatory framework of the viatical settlement industry in the Viatical Settlement Act in part X, ch. 626, F.S. ("the Act"), which is administered by the Office of Insurance Regulation (OIR). The Act requires VSPs to comply with licensure, annual reporting, anti-fraud, transactional, and disclosure provisions, and sets forth administrative, criminal, and civil penalties for violations of the Act.

In the early 2000s, a related product known as "stranger-originated life insurance" (also known as STOLI) emerged. While STOLI initially appears similar to legitimate viatical settlements, STOLI is a scheme designed to procure life insurance on individuals, often using fraudulent means, such as misrepresentation, falsification, or omission of material facts in the life insurance application, so that an assignment or sale of a policy functions as a subterfuge that circumvents the insurable interest requirement. While various provisions in the Act and the Insurance Code currently prohibit practices that may involve STOLI, they do not specifically address STOLI.

The bill amends the Act to specifically define STOLI as a "fraudulent viatical settlement act," to prohibit STOLI as a practice that lacks an insurable interest in the insured at the time of policy origination, and to make STOLI void and unenforceable. Additionally, the bill:

- Increases maximum administrative fines that the OIR may impose for certain violations, increases the $100,000 deposit requirement to $250,000, and creates new felony offenses for certain viatical settlement practices;
- Establishes new disclosure and annual reporting requirements and conflicts of interest prohibitions for VSPs;
- Requires VSPs to file their advertising and marketing materials with the OIR prior to entering into viatical contracts and to maintain documentation of compliance with their anti-fraud plans;
- Increases the non-contestability period from two years to five years, subject to certain exceptions; and
- Requires VSPs to provide certain documentation to insurers for verification of coverage, prior to entering into a viatical settlement contract.

The bill has an indeterminate positive fiscal impact on state revenues deposited into the Insurance Regulatory Trust Fund, as it increases administrative fines for violations of the Act. In addition, the bill has an indeterminate fiscal impact to state expenditures of the OIR, as it requires the OIR to review VSPs' advertising materials. The Criminal Justice Impact Conference met on January 29, 2016 and determined the impact of the bill on the Department of Corrections prison beds to be insignificant. While the bill increases regulatory requirements and administrative fines on VSPs, the bill may have a positive effect on consumers and life insurers by strengthening consumer protections and reducing fraudulent life insurance claims and litigation.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Life Insurance and the Insurable Interest Requirement

Life insurance allows an individual to set aside money in the present (through the payment of premiums) to provide some measure of financial security for his or her surviving beneficiaries upon his or her premature death. The proceeds allow survivors to pay off debts and other expenses and provide a source of income to replace that lost by the death of the insured.[1] Life insurance dates to ancient Rome where burial clubs covered the cost of members' funeral expenses and provided monetary benefits to survivors. Modern life insurance became commercially important in the 15th century Mediterranean mercantile economies and through its introduction to England in the 16th century. Although it served a legitimate purpose of risk avoidance and mitigation, life insurance drew a strong appeal to the gambling instincts of middle-class individuals with no financial interest in the lives of popes, princes, and other prominent people and who took out insurance policies on these strangers' lives as mere wagers. To put an end to the use of life insurance contracts as wagering devices, the British Parliament enacted the Life Assurance Act of 1774, holding that any life insurance contract without an *insurable interest* in the life of the insured would be null and void.[2]

In the late 19th century, the U.S. Supreme Court defined "insurable interest" as "a reasonable expectation of advantage or benefit from the continuance of [the insured's] life"; in other words, an insurable interest is found when an individual has a greater interest in the survival of the insured than in the insured's death.[3] Subsequently, most American courts recognized the insurable interest requirement for life insurance policies, finding that life insurance policies purchased without an insurable interest violate public policy because they constitute a mere wager that creates a sinister desire for the early death of the insured.[4] Today, it is recognized that an individual has an insurable interest as to his or her own life, body, and health. In addition, an insurable interest is founded on a "love and affection" interest for persons related by blood or law; as to other persons, a lawful and substantial economic interest in the continued life, health, or bodily safety of the insured person,[5] such as corporate-owned insurance on the life of an officer or director. These recognized interests are intended to ensure life insurance's purpose as a financial protection tool, rather than a wagering device.

Florida's insurable interest requirement is codified at s. 627.404, F.S., which lists nine exclusive categories in which an insurable interest as to life, health, or disability insurance are recognized, including the "own life, body and health," "love and affection," and "substantial pecuniary advantage" grounds mentioned above.[6] The statute requires that an insurable interest exist at the time the insurance contract is made, but need not exist after the inception date of coverage under the contract. Thereafter, life insurance is an asset that may be freely sold, transferred, or devised, which is consistent with the parties' freedom to contract for the assignment or non-assignment of policies in s. 627.422, F.S.

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[1] OFFICE OF INSURANCE REGULATION, *Life Insurance*, http://www.floir.com/Sections/LandH/Life/default.aspx (last viewed Feb. 4, 2016).

[2] Susan Lorde Martin, *Betting on the Lives of Strangers: Life Settlements, STOLI, and Securitization*, 13 U. PA. J. BUS. L. 173, 174 (2010); OFFICE OF INSURANCE REGULATION, *Report of Commissioner Kevin M. McCarty: Stranger-Originated Life Insurance and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurable Interest Law* (Jan. 2009), ("2009 OIR Report"), p. 6.

[3] *Warnock v. Davis*, 104 U.S. 775, 779 (1881); *Connecticut Mut. Life Ins. Co. v. Schaefer*, 94 U.S. 457, 460 (1876).

[4] *Id.*; *Aetna Life Ins. Co. v. France*, 94 U.S. 561 (1876) and *Grigsby v. Russell*, 222 U.S. 149 (1911).

[5] OFFICE OF INSURANCE REGULATION, *Report of Commissioner Kevin M. McCarty: Stranger-Originated Life Insurance and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurable Interest Law* (Jan. 2009), ("2009 OIR Report"), p. 7.

[6] These grounds were added to s. 627.404, F.S., by the Florida Legislature in 2008. Ch. 2008-36, Laws of Fla.

Viatical Settlements: The Secondary Market of Life Insurance

In some instances, life insurance policyholders seek to sell their policies to third parties (usually private, individual investors) as a way to obtain cash for medical expenses or other needs. In these transactions, known as "viatical settlements," companies called *viatical settlement providers* would usually purchase the policy from the insured (*the viator*) for more than its cash surrender value, but less than the face value of the policy. The settlement is usually based upon the projected life expectancy of the insured, the amount of built-up cash in the policy, and other criteria, and is often negotiated by a *viatical settlement broker* on the viator's behalf. The purchaser of the policy then pays the premiums to sustain the policy until the insured's death; as a result, the sooner the viator was the expected to die, the higher the settlement offer is likely to be.

Viatical settlements emerged during the HIV/AIDS epidemic in the 1980s, enabling terminally ill patients with short life expectancies who could no longer work and afford the policy premiums to sell their life insurance policies at a cash discount to pay for high medical care expenses. In the early days of the epidemic, AIDS patients generally died within months of their diagnoses, resulting in fairly quick, significant returns to investors,[7] who in those days were typically senior individuals who risked their savings in what was represented as a safe investment and marketed as a compassionate way to help dying patients. However, innovations in AIDS treatment in the early 1990s significantly improved life expectancies of AIDS patients, sometimes even outliving their investors, which disrupted mortality assumptions and diminished investor returns. As a result, some viatical settlement providers stopped brokering new viatical settlements, while others engaged in fraudulent practices, such as pyramid schemes.[8]

Because investors' expectations of returns can trigger the application of state and federal securities law, viatical settlements are widely treated as a hybrid transaction implicating both insurance law and securities law. *Insurance* law applies to protect the policy owner or viator in the "front-end" transaction with the viatical settlement provider through licensing, disclosure reporting, and other requirements. On the other hand, *securities* law applies to the "back-end" transaction to protect investors in viatical settlement investments by state securities regulators, and in some circumstances, the U.S. Securities and Exchange Commission.[9]

In response to increasing concerns over consumer protection in the viatical settlement market, several state insurance regulators (through the National Association of Insurance Commissioners (NAIC)) and the National Association of Insurance Legislators (NCOIL)[10] developed model state legislation regulating the "front-end" transaction of viatical settlements in 1993 and 2007, respectively.

Regulation of Viatical Settlements in Florida

In 1996, Florida enacted the Viatical Settlement Act (codified as part X, ch. 626, F.S.; "the Act")[11] as a regulatory framework for viatical settlement providers (VSPs) and viatical settlement brokers by the Department of Insurance, the predecessor agency to the current Office of Insurance Regulation (OIR).[12] The Act sets forth requirements for licensure, annual reporting, certain minimum disclosures to viators, transactional procedures, adoption of anti-fraud plans, and administrative, civil, and criminal

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[7] Kelly J. Bozanic, *An Investment to Die For: From Life Insurance to Death Bonds, the Evolution and Legality of the Life Settlement Industry*, 113 PENN. ST. L. REV. 229, 233-234 (2008).

[8] OFFICE OF INSURANCE REGULATION, *Secondary Life Insurance Market Report to the Florida Legislature* (Dec. 2013) ("2013 OIR Report"), p. 9.

[9] GOVERNMENT ACCOUNTABILITY OFFICE, Report to the Special Committee on Aging, U.S. Senate: Life Insurance Settlements, GAO-10-775 (Jul. 2010), p. 9, at http://www.gao.gov/assets/310/306966.pdf .

[10] The NAIC is the standard-setting and regulatory support organization created and governed by the chief insurance departments that regulate the conduct and solvency of insurers in their respective states or territories. NAIC, *About the NAIC*, http://www.naic.org/index_about.htm (last visited Feb. 4, 2016).

[11] Ch. 96-336, Laws of Fla.

[12] Following the 2003 governmental reorganization, authority over the Act was transferred to the OIR. Ch. 2003-261, Laws of Fla. Additionally, the Act requires *life expectancy providers* to register with the OIR. Life expectancy providers determine life expectancies or mortality ratings for viatical settlements. ss. 626.9911(4) and 626.99175, F.S.

penalties. The Act also provides the OIR with examination and enforcement authority over VSPs and brokers; review and approval authority over the viatical settlement contracts and forms; rulemaking authority; and provided that a violation of the Act is an unfair trade practice under the Insurance Code. The Act does not authorize the OIR to regulate the rate or amount paid as consideration for a viatical settlement contract.[13]

Since its inception, the Act has been substantively amended seven times to enhance consumer protections and to address changes in the viatical settlement industry.[14] For example, prior to July 1, 2005, viaticals in Florida were regulated exclusively as insurance. In 2005, following numerous consumer complaints and findings of investor harm in the "back-end transaction," the Legislature amended the Act to provide that *viatical settlement investments* are securities under the Florida Securities and Investor Protection Act (ch. 517, F.S.), which is enforced by the Office of Financial Regulation (OFR) and triggers requirements of full and fair disclosure to investors and a securities dealer license from the OFR.[15] The 2005 legislation also provides that a person or firm who offers or attempts to negotiate a viatical settlement between an insured (viator) and a VSP for compensation is a *viatical settlement broker* who must be licensed with the Department of Financial Services (DFS) as a life insurance agent with a proper appointment from a VSP. Viatical settlement brokers owe a fiduciary duty to the viator.[16]

Since the inception of the Act, the viatical settlement market has evolved both in terms of the types of policies transacted by viatical settlement providers and the type of investors.

- "Life settlements" are offered to non-terminally ill insureds that no longer want, need, or can afford their policies and as an alternative to exercising a redemption or accelerated death benefit clause in their policies. However, the Act treats life settlements the same as viatical settlements for purposes of regulation.[17]
- Additionally, instead of the private individuals who invested in viaticals during the HIV/AIDS epidemic, institutional investors (such as investment banks and hedge or pension funds) now often invest in large blocks of policies sold as a portfolio in the secondary market.[18] In 2013, the Legislature directed the OIR to review Florida law and regulations to determine whether there were adequate protections for purchasers of life insurance policies in the secondary life insurance market.[19] Following a public hearing conducted by the OIR, in which both life insurers and institutional investors participated, the OIR published a report, concluding that adequate protections for institutional purchasers in the secondary life insurance market existed and that their recommendations did not warrant legislative action at the time.[20]

Stranger-Originated Life Insurance (STOLI)

Another evolution of the viatical settlement market is a practice known as "stranger-originated (or stranger-owned) life insurance" (STOLI), which emerged in the 2000s. In a STOLI transaction, an individual (typically a senior) is encouraged to take out insurance on his or her own life, sometimes in the millions of dollars, and then assigns the policy to an investor or group of investors (the "stranger") who pay the individual a large cash settlement in exchange for the ownership rights to the policy, including the right to receive the proceeds upon the insured's death.

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[13] s. 626.9926, F.S.
[14] Excluding reviser's bills and the 2003 governmental reorganization bill. *See* chs. 98-164; 99-212; 2000-344; 2001-207; 2001-247; 2005-237; and 2007-148, Laws of Fla.
[15] Ch. 2005-237, Laws of Fla.
[16] ss. 626.9911(9) and 626.9916, F.S.
[17] The 2000 legislation amended the definition of "viator," who is the owner of a life insurance policy seeking to enter into a viatical settlement contract, to remove language restricting such policy to one "insuring the life of an individual with a catastrophic or life-threatening illness." *See* ch. 2000-344, Laws of Fla.
[18] 2013 OIR REPORT, p. 13. One participant in the 2013 OIR hearing observed that institutional investors primarily participate in the securitization of life settlements, or the nominal "tertiary" market, which feeds liquidity into the secondary life insurance market (i.e., the subsequent trading after the policy is first sold). *Id.* at Appendix A, Transcript of Public Hearing, pp. 125-126.
[19] Ch. 2013-40, §6, Laws of Fla. (2013 General Appropriations Act, p. 316).
[20] 2013 OIR REPORT, pp. 50-51.

On the surface, STOLI may appear similar to legitimate viatical or life settlements in that a third party buys a policy from an insured in which they have no insurable interest. However, the critical difference is that in legitimate settlements, an insured initially buys life insurance in a good-faith intent to protect valid insurable interests (i.e., to protect family members or a business from the risk of a premature death), but subsequently decides to sell the policy to a third party due to a change in circumstances that may not warrant the policy (such as divorce, death of an intended beneficiary, or the need for immediate cash due to illness or other loss).

Unlike legitimate viaticals, STOLI lacks an insurable interest at the time of the contract, thereby violating public policy against wagering on the lives of others. The life insurance policy is not acquired in good faith in that the parties intend at the outset that the *investors* (who lack an insurable interest in the insured) receive the proceeds, directly or indirectly.[21] STOLI is a scheme designed to procure life insurance on individuals, often using fraudulent means, such as misrepresentation, falsification, or omission of material facts in the life insurance application, so that an assignment or sale of a policy functions as a subterfuge that circumvents the insurable interest requirement. As the Uniform Law Commission noted:

> Those who benefit from STOLI transactions (typically investors in the secondary markets) claim that it is an appropriate use of life insurance consistent with applicable legal principles, including the free transferability of assets. Others, including life insurers, oppose the use of STOLI on the ground that is a perversion of the life insurance asset and leads to the moral hazard concerns that insurable interest doctrines were intended to mitigate.[22]

STOLI also differs from legitimate viatical settlements with the following common characteristics:

- Typically targets senior citizens who are induced with gifts, promises of free insurance, or monetary gain;
- Commonly financed through non-recourse "premium finance loans";
- Commonly structured through the use of an irrevocable trust, making it difficult for the life insurance company to know that the policy has been sold;
- Premiums are paid for two years (i.e., the contestable period); and
- Often involves misrepresentation, falsification, or omission of material facts (also known as "cleansheeting") in the life insurance application and inflated underwriting practices, such as the applicant's net worth, in order to obtain a policy with a high face value.

According to the OIR, STOLI impacts consumers (both individual investors and insureds) and insurers in a number of ways:[23]

- Seniors may exhaust their life insurance purchasing capability and not be able to protect their own family or business.
- The incentives, especially cash payments, used to lure seniors to participate in STOLI schemes are taxable as ordinary income.
- Seniors may subject themselves or their estates to potential liability in the event the life insurance policy is rescinded by an insurer who discovers fraud.
- Seniors may encounter unexpected tax liability from the sale of the life insurance policy.[24]
- The "free" insurance is not free and may be subject to tax based on the economic value of the coverage.

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[21] AALU, NAIFA, and ACLI, *STOLI: The Problem and the Appropriate State Response*, p. 4, on file with the Insurance & Banking Subcommittee staff.

[22] UNIFORM LAW COMMISSION, *Insurable Interest Amendment to the Uniform Trust Code Summary*, at http://www.uniformlaws.org/ActSummary.aspx?title=Insurable%20Interests%20Amendment%20to%20the%20Uniform%20Trust%20Code (last visited Feb. 4, 2015).

[23] Office of Insurance Regulation, Agency Analysis of 2016 House Bill 445 ("OIR Agency Analysis"), p. 6 (Nov. 15, 2015); Additionally, s. 626.9923, F.S., requires VSPs to disclose certain risks to viators, such as tax and Medicaid eligibility consequences.

[24] *See* IRS Rev. Ruls. 09-13 and 09-14, regarding taxation of proceeds from settlements as capital gains ordinary income and taxation on a post-settlement basis.

- Seniors have to give the purchaser, and subsequent purchasers, access to their medical records when they sell their life insurance policy in the secondary market so that investors know the health status of the insured. The investors want to know the "status" of their investment and how close they are to getting paid.
- STOLI may lead to an increase in life insurance rates for the over-65 population.
- If STOLI practices continue to proliferate, the U.S. Congress may remove the tax-free status of life insurance proceeds, or may provide for federal regulatory oversight of the viatical settlement industry.

Legislative, Regulatory, and Litigation Approaches to STOLI

Over 30 states currently prohibit STOLI, generally through some combination of the NAIC and NCOIL model acts, in addition to common law or statutory insurable interest laws. STOLI has resulted in significant litigation, criminal and regulatory enforcement actions, both nationally and in Florida.[25]

Below are several legal grounds currently available to the OIR and life insurers in STOLI transactions:

- *Grounds for disciplinary action under the Act*: Currently, the Act authorizes the OIR to impose fines between $2,500 to $10,000, or to suspend, revoke, deny, or refuse to renew the license of any VSP found to be engaging in certain acts, such as fraudulent or dishonest practices, dealing in bad faith with viators, or violating any provision of the Act or the Insurance Code. The OIR may also impose cease and desist orders and immediate final orders for violations of the Act.[26]
- *Misrepresentation on an application*: Currently, s. 627.409, F.S., provides that misrepresentation, omission, concealment of fact, or incorrect statements on an application for an insurance contract "may prevent recovery" in certain cases. However, this remedy is viewed as inadequate, because there are no criminal penalties and the only civil penalty available is an action for rescission by the life insurer.
- *Agent regulation*: Various provisions of the Insurance Code authorize the DFS to suspend or revoke the license or appointment of licensees, agencies, or appointees on various grounds, such as using fraudulent or dishonest practices in the conduct of business under the license.[27]
- *Unfair Insurance Trade Practices Act*: Section 626.9541, F.S., lists several unfair methods of competition and unfair or deceptive acts or practices. Each violation of this statute can result in fines ranging from $5,000 to $75,000, depending on the willfulness and particular violation. In addition, "twisting" and "churning" are first-degree misdemeanors, while willfully submitting false signatures on an application is a third-degree felony.[28] While VSPs are subject to this statute by way of s. 626.9927, F.S., and STOLI transactions do share some components of these practices, the statute was written for the initial sale of an insurance policy to an insured and not specifically for STOLI, making it difficult and unwieldy for the OIR to apply the provisions to secondary sales of life insurance policies.[29]
- *Insurable Interest Litigation by Life Insurers*: Insurers and investors have relied on two dueling statutes which are not in the Act.
    - As noted above, Florida expanded its insurable interest statute, s. 627.404, F.S., in 2008 to clarify when an insurable interest may be validly recognized for life insurance purposes. Life insurers have relied on this statute in filing suit to rescind the policies subsequently transferred in a STOLI transaction for a lack of insurable interest at the time of the policy.

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[25] For a listing of OIR enforcement actions, see OIR, *Viatical Criminal, Civil and Regulatory Actions*, http://www.floir.com/sections/landh/viaticals/ccr_actions.aspx (last visited Feb. 4, 2015) and 2013 OIR Report, *Appendix C: Florida Regulatory and Enforcement Actions Pertaining to Viatical Settlement Providers*.
[26] ss. 626.9914 and 626.99272 , F.S.
[27] ss. 626.611, 626.6115, 626.6215, and 626.621, F.S.
[28] s. 626.9541, F.S.
[29] OIR Agency Analysis, p. 2.

- However, another statute, s. 627.455, F.S., requires insurers to include an incontestability clause in their policies that bars a challenge to the policy after it has been in force for two years. Securities intermediaries (acting for the institutional investors) have relied on this statute as a kind of statute of limitations to seek dismissal of insurers' rescission cases, arguing that a tardy challenge is barred regardless whether the policy was made with an insurable interest at inception.
- In separate cases, the U.S. District Court for the Southern District of Florida reached different interpretations on the interplay of these statutes.[30] These appeals were consolidated to the U.S. Court of Appeals for the Eleventh Circuit, which noted that there are no cases decided by Florida courts that specifically address whether a party can challenge an insurance policy as being void ab initio for lack of an insurable interest if the challenge is made after the two-year contestability period, and if so, whether the individual with the required insurable interest must procure the policy in good faith. As a result, the Eleventh Circuit certified questions to the Florida Supreme Court last year for a determination of Florida law on the conflict between these two statutes.[31]

However, current law does not specifically define STOLI, nor does it have a specific *regulatory* prohibition on STOLI or policies lacking an insurable interest at inception.

Effect of the Bill

The bill increases the OIR's regulatory authority over the Act in areas that the OIR believes are necessary to protect Florida consumers by clarifying fraudulent acts, prohibited practices, explicitly prohibiting STOLI transactions, requiring increased disclosures to viators, and increasing transparency of VSPs' operations. These provisions are largely based on a combination of model viatical settlement legislation from the NAIC and the NCOIL. The bill focuses on the "front-end" transaction by viatical settlement providers, not the "back-end" (securities regulation).

Definitions (Section 1)

As stated by the OIR, many activities described in this bill are already prohibited by current laws addressing fraud and illegal activities,[32] although, as noted above, many of these current laws may be ineffective or difficult to enforce. The bill addresses the historical prohibition on wagering on the lives of strangers by making "stranger-originated life insurance practices" and "fraudulent viatical acts" violations of the Act in section 3 of the bill, relating to the OIR's administrative authority over the Act.

Section 1 of the bill creates the following definitions in s. 626.9911, F.S.:

- *Business of viatical settlements*: an activity involved in offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypotheticating of, or acquiring in other manner, an interest in a life insurance policy by means of a viatical settlement contract.
- *Fraudulent viatical settlement act* includes a comprehensive list, including preparing false or fraudulent material information or the concealment of material information related to a viatical settlement contract or life insurance policy; perpetuating or preventing the detection of a fraud; prohibitions on the use of trusts or in STOLI transactions; and the failure to disclose to the insurer when requested by the insurer that the prospective insured has undergone a life expectancy evaluation by any person other than the insurer or its authorized representatives in connection with the issuance of a policy.

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[30] *Pruco Life Ins. V. Brasner*, 2011 WL 134056 (S.D. Fla. Jan. 7, 2011), and *Pruco Life Ins. Co. v. U.S. Bank*, 2013 WL 4496506 (S.D. Fla. Aug. 20, 2013).
[31] *Pruco Life Ins. Co. v. Wells Fargo Bank, N.A.*, 780 F.3d 1327 at 1336 (11th Cir. C.A. 2015). The appeal, currently pending at the Florida Supreme Court (Case No. SC15-382), is scheduled for oral argument on March 10, 2016, and will go back to the Eleventh Circuit for final disposition.
[32] OIR Agency Analysis, p. 2.

- *Stranger-originated life insurance practice* is an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. This includes the creation of a trust or other entity that has the appearance of an insurable interest to initiate policies for investors.
    - Section 13 of the bill creates s. 626.99289, F.S., to make any contract, agreement, arrangement, or transaction that is entered into for the furtherance of a STOLI practice void and unenforceable.

Section 1 amends the following current definitions in s. 626.9911, F.S.:

- *Related form*: Related forms are any forms created by or on behalf of a VSP licensee, such as powers of attorney or a release of medical information form. Currently, the Act defines these to mean forms which a viator is required to sign. The bill adds insureds as persons required to sign these forms.
- *Viatical settlement contract:* Viatical settlement contracts are written agreements between a VSP, or its related provider trust, and the viator as the agreement to transfer ownership or change the beneficiary designation of a life insurance policy at a later date, and includes specified information. The bill amends this definition to include the sale of an interest in a trust or other entity if such entity was formed or used for the purpose of acquiring life insurance contracts that insure the life of a person residing in Florida. It also clarifies that a "viatical settlement contract" does not include accelerated death provisions in a life insurance policy or loan or advance from the issuer of the policy to the policy owner. This is consistent with the current definition of "viatical settlement provider," which excludes life and health insurers that have lawfully issued a life insurance policy that provides accelerated benefits to terminally ill policyholders or certificateholders.
- *Viatical settlement provider:* The bill deletes the exclusion of, "other licensed lending institution," from the definition of a "viatical settlement provider," as it could be interpreted to be a premium finance company or some other entity with little or no regulatory oversight.

Annual Statement Filings (Section 2)

Section 2 of the bill amends s. 626.9913, F.S., to require a VSP to include additional information in their annual statement filings to the OIR. The bill codifies the language that is currently collected by the OIR to ensure VSPs consistently provide this information,[33] and adds a requirement for providers to submit total commissions or compensation, including across jurisdictions and on a yearly basis. Previously, the OIR sought to collect this information from VSPs through a proposed rule; however, the proposed rule was successfully challenged as an invalid exercise of legislative authority.[34] The bill authorizes the Financial Services Commission[35] to adopt rules to implement this section.
The bill increases the deposit requirement for VSPs to $250,000, from $100,000, which has not been increased since the Act's adoption in 1996.[36] Additionally, the bill also deletes obsolete language pertaining to surety bond requirements and deposits.

Grounds for Administrative Action against VSPs (Section 3)

Section 3 of the bill amends s. 626.9914, F.S., to add "fraudulent viatical settlement act" to the list of grounds for suspension, revocation, denial or non-renewal of a VSP license. The bill also increases maximum administrative fines for non-willful violations of this section from $2,500 to $10,000 and willful violations from $10,000 to $25,000. These new caps match the maximum fines that OIR can assess against a VSP pursuant to s. 626.99272(2), F.S., for any violations of the entire Act, not just the enumerated grounds in s. 626.9914, F.S.

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[33] *Id.* at p. 2.
[34] *LISA v. Fin. Serv. Comm'n*, Case No. 09-0386RP (Fla. DOAH May 7, 2009); *partly affirmed* in *Office of Ins. Reg. v. LISA*, 31 So. 3d 953 (Fla. 1st DCA 2010).
[35] Pursuant to s. 20.121(3), F.S., the Financial Services Commission (the Governor and Cabinet) serves as the agency head for purposes of rulemaking and appoints the OIR's Commissioner, who serves as the agency head for purposes of final agency action for all areas within the OIR's regulatory authority
[36] The NAIC model viatical settlement act requires a $250,000 deposit.

The bill also expands the prohibition in s. 626.9914(1)(i), F.S., on VSPs from employing any person who materially influences the licensee's conduct and who fails to meet the requirements of the Act, to apply to contractors as well.

Disclosures to Viators (Section 5)

Section 5 of the bill creates s. 626.99185, F.S., to establish new requirements for a VSP to disclose certain amounts paid to any broker along with a reconciliation of the difference between the gross offer and the net proceeds.[37] A viatical settlement provider, prior to executing a viatical contract, is required to obtain a signed and dated copy of this disclosure statement and any amended disclosure statement from the broker or viator. This new section also requires the VSP to maintain the statement for copying and inspection by the OIR pursuant to its examination authority in s. 626.9922(2), F.S.

Prohibited Practices & Conflicts of Interest (Section 8)

Section 8 of the bill creates s. 626.99273, F.S., titled "prohibited practices and conflicts of interest," which is based on the NAIC Model Act. This section prohibits a broker from sharing common control with or receiving funds from the VSP. It also requires VSPs to file their advertising and marketing materials to the OIR prior to entering into any viatical contracts. The advertising and marketing materials along with insurance agents, insurers, brokers and VSPs are prohibited from stating or implying that the life insurance is free for any period of time, which is currently an unfair insurance trade practice in s. 626.9541(1)(n), F.S. The bill's definition and prohibition of "fraudulent viatical settlement acts" also includes a violation of subsections (1) or (2), relating to conflicts of interest, which in turn are grounds for administrative action by the OIR. The bill also provides authority to the Financial Services Commission to adopt rules to implement this section.

Prohibited Practices – Criminal Penalties (Section 9)

Section 9 of the bill amends the criminal penalties statute of the Act, s. 626.99275, F.S., to criminalize:

- Knowingly entering into a viatical settlement contract before the application for or the issuance of a life insurance policy that is the subject of a viatical settlement contract, or during the five-year incontestability period of s. 626.9987, F.S., unless the viator provides a sworn affidavit and accompanying documentation in accordance with s. 626.9987, F.S.;
- Knowingly issuing, soliciting, marketing or promoting the purchase of a life insurance policy for the purposes of or emphasis on selling the policy; or
- Engaging in any fraudulent viatical settlement act.

Depending on the value of the insurance policy, these violations constitute a felony of the first, second, or third degrees.

Incontestability Period, Notice to Insurers, & Verification of Coverage (Sections 10 and 12)

Currently, the Act contains a contestability statute (s. 626.99287, F.S.), which provides that viatical settlements entered into within two years after the issuance of the insurance policy are generally void and unenforceable by either party, except in certain circumstances warranting a hardship exception, such as a viator's certification of a life-threatening illness or death of a viator's spouse. In these cases, the VSP submits the request to the insurer, who must "timely" respond. This provision does not preclude an insurer from contesting the validity of any policy on the grounds of fraud.

Section 12 of the bill amends s. 626.99287, F.S., to increase the incontestability period from 2 years to five years, thus requiring certain conditions be met within a 5-year period before applying for or entering into a life insurance policy that is the subject of a viatical settlement contract, and requires that the viator provide a sworn affidavit and accompanying documentation certifying to the VSP that one or more of these conditions were met during the 5-year period. The bill also creates an exception to incontestability if, after more than 2 years from entering into a viatical settlement contract, at all times

[37] Currently, s. 626.99181, F.S., requires viatical settlement *brokers* to disclose their compensation to the viator.

during the policy's issuance, the viator certifies that: (a) policy premiums have been funded exclusively with unencumbered assets; (b) no agreement with another party has been entered into to purchase the policy; and (c) the insured and the policy have not been evaluated for settlement.

Section 10 of the bill creates a notification to insurer statute (new s. 626.99276, F.S.), which clarifies the responsibilities of all parties involved in a viatical settlement and outlines the documents that must be submitted to the insurer as well as responsibilities of the insurer when dealing with the viatication of a policy. This section requires a viatical settlement provider to give notice to an insurer, including a copy of a sworn affidavit and documentation certifying that certain conditions have been met (as required by s. 626.99287, F.S., of the bill), if either the viator submits a request to the insurer for verification of coverage, or if the viatical settlement provider submits a request to transfer the policy or certificate to the provider. In response to a request for verification of coverage or transfer of policy, the section prohibits an insurer from requiring that the viator, insured, provider, or broker sign any disclosures or forms not specifically approved by the OIR for viatical settlement contracts. The section also requires that upon receipt of a request of a change of ownership or beneficiary, the insurer respond in writing within 30 days.

Anti-Fraud Plan Recordkeeping (Section 11)

Section 11 of the bill amends the anti-fraud statute (s. 626.99278, F.S.), to require licensed VSPs to maintain documentation of their compliance with their anti-fraud plan, documentation pertaining to material inconsistencies between medical records and insurance applications, and documentation of their reporting to the Division of Insurance Fraud. The documentation must be maintained in accordance with s. 626.9922, F.S., which requires licensees to maintain books and records for at least 3 years after the death of the insured and must be made available to the OIR or DFS for inspection during reasonable business hours.

Void and Unenforceable Contracts, Agreements, Arrangements, & Transactions (Section 13)

Section 13 of the bill creates s. 626.99289, F.S., to make any contract, agreement, arrangement, or transaction that is entered into for the furtherance of a "STOLI practice" (as defined in section 1 of the bill) void and unenforceable.

Cross-References (Sections 4, 6, and 7)

Sections 4, 6, and 7 of the bill amend ss. 626.99175, 626.9924, and 626.99245, F.S., respectively, to delete obsolete provisions and to correct cross-references.

B. SECTION DIRECTORY:

Section 1. Amends s. 626.9911, F.S., relating to definitions.
Section 2. Amends s. 626.9913, F.S., relating to viatical settlement provider license continuance; annual report; fees; deposit.
Section 3. Amends s. 626.9914, F.S., relating to suspension, revocation, denial, or nonrenewal of viatical settlement provider license; grounds; administrative fine.
Section 4. Amends s. 626.99175, F.S., relating to life expectancy providers; registration required; denial, suspension, revocation.
Section 5. Creates s. 626.99185, F.S., relating to disclosures to viator of disbursement.
Section 6. Amends s. 626.9924, F.S., relating to viatical settlement contracts; procedures; rescission.
Section 7. Amends s. 626.99245, F.S., relating to conflict of regulation of viaticals.
Section 8. Creates s. 626.99273, F.S., relating to prohibited practices and conflicts of interest.
Section 9. Amends s. 626.99275, F.S., relating to prohibited practices; penalties.
Section 10. Creates s. 626.99276, F.S., relating to notification to insurer required.
Section 11. Amends s. 626.99278, F.S., relating to viatical provider anti-fraud plan.
Section 12. Amends s. 626.99287, F.S., relating to contestability of viaticated policies.
Section 13. Creates s. 626.99289, F.S., relating to void and unenforceable contracts, agreements, arrangements, and transactions.
Section 14. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill has an indeterminate positive fiscal impact on state revenues deposited into the Insurance Regulatory Trust Fund, as it increases administrative fines for violations of the Act. Specifically, the bill increases maximum administrative fines for non-willful violations of s. 626.9914, F.S., from $2,500 to $10,000, and willful violations of the same statute from $10,000 to $25,000.

2. Expenditures:

The bill has an indeterminate fiscal impact to state expenditures of the OIR. Specifically, the bill requires the OIR to review additional forms and advertising materials of VSP's. As there are currently no rules concerning viatical advertising, the OIR states that it is not possible to anticipate the volume of advertising materials the OIR may receive or the time staffing resources will have to expend reviewing such advertising.[38]

In addition, the DFS noted that its investigations in viatical settlements primarily result from STOLI transactions, and that the bill's prohibition on STOLI transactions may significantly reduce their viatical-related investigative caseload. The DFS also noted that the bill may be effective in reducing multiple loopholes and devices used to commit fraud in the viatical industry.[39]

The Criminal Justice Impact Conference met on January 29, 2016 and determined the impact of the bill on the Department of Corrections prison beds to be insignificant due to the creation of new felony offenses in s. 626.99275, F.S. These new offenses would apply to persons who knowingly enter into a viatical settlement contract in violation of the incontestability period and who do not meet the exceptions, for knowingly issuing or promoting the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy, or engaging in a fraudulent settlement act.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. The bill increases regulatory requirements and administrative fines on viatical settlement providers. However, the bill may benefit consumers and life insurers by reducing the volume of lawsuits and fraudulent or speculative claims paid out by insurers, which could reduce overall premium costs.[40]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

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[38] OIR Agency Analysis, p. 4.
[39] Department of Financial Services, Agency Analysis of 2016 House Bill 445, p. 3 (Jan. 6, 2016).
[40] *Id.*

2. Other:

The bill is silent as to if or how it applies to policies issued or viaticated before the effective date of July 1, 2016. However, s. 624.21, F.S., provides that each amendment to the Insurance Code[41] (which includes the Act) shall be construed to operate prospectively, unless a contrary legislative intent is specified. This is consistent with the constitutional principle that unless the Legislature states otherwise, legislation is presumed only to operate prospectively, especially when retroactive application would impair existing rights. Even where the Legislature expressly states intent for a statute to apply retroactively, courts will reject such an application if the statute impairs a vested right, creates a new obligation, or imposes a new penalty.[42]

State and federal appellate courts in California have held that the California 2009 anti-STOLI law (which, like this bill, established a statutory definition of STOLI and classified such transactions as fraudulent acts) does not apply retroactively to policies written or to beneficial interests transferred before the law took effect.[43] Similarly, the New York Court of Appeals held that New York law existing prior to anti-STOLI legislation (enacted in 2009) applied in a 2010 STOLI challenge.[44]

Under these principles (and regardless of how the Florida Supreme Court interprets the insurable interest and contestability statutes or how the Eleventh Circuit Court of Appeals adjudicates the parties' rights and obligations in *Pruco)*, it is unlikely a court would uphold retroactive application of subsequently enacted anti-STOLI legislation such as this bill.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority to the Financial Services Commission regarding annual reporting, advertising and marketing, and conflicts of interest requirements (sections 2 and 8 of the bill).

C. DRAFTING ISSUES OR OTHER COMMENTS:

- DFS noted that section 5 of the bill could be clarified as to the viatical settlement broker's responsibility in securing disclosure statements and providing any mandated copies to the viator.[45]
- The examination authority statute, s. 626.9922, F.S., which is not amended by the bill, refers to certain books and records that must be maintained and made available to the OIR. Specifically, subsection (2) of the statute requires VSP licensees to maintain books, records, and so forth, "relating to all transactions of viatical settlement contracts, life expectancies, or viatical settlement purchase agreements made before July 1, 2005" for three years after the insured's death. This provision could be clarified so as not to limit interpretation and application of this statute to only pre-2005 agreements and contracts.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

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

- Amends the definition of "stranger-originated life insurance practice" to include the creation of a *non-trust entity* that has the appearance of an insurable interest to initiate policies for investor, which violates insurable interest laws and the prohibition against wagering on human life.
- Clarifies viatical settlement providers' new annual reporting requirements in s. 626.9913, F.S., so that:
    - Certain policy data must be reported for *each year of the most recent 5 years*, and not one aggregate filing for that 5 year period, and
    - Total proceeds or compensation paid to policy owners should be reported *for the most recent calendar year*.

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[41] Section 624.01, F.S., provides that chs. 624-632, 634-636, 641-642, 648, and 651 constitute the Florida Insurance Code.
[42] *Menendez v. Progressive Exp. Ins. Co., Inc.*, 35 So.3d 873 (Fla. 2010).
[43] *Lincoln Life & Annuity Co. of N.Y. v. Berck,* 2011 WL 1878855 (Cal. Ct. App. 2011), *review denied* Aug. 31, 2011; *Wells Fargo Bank, N.A. v. American Nat. Ins. Co.*, 493 Fed.Appx. 838 (9th Cir. 2012).
[44] *Kramer v. Phoenix Life Ins. Co.*, 15 N.Y. 3d. 539 at 549, n. 5 (2010).
[45] DFS Agency Analysis, p. 3.

- Increases the minimum deposit requirement in s. 626.9913(3), F.S., from $100,000 to $250,000;
- Expands the prohibition in s.626.9914(1)(i), F.S., on viatical settlement providers from employing any person who materially influences the licensee's conduct and who fails to meet the requirements of the Act, to apply to contractors as well.
- Replaces the undefined term life insurance "producers" in new s. 626.99273, F.S., with the term "agent," which is defined in s. 626.015(2), F.S., as including producers. As a result, the bill prohibits agents (and other entities) from representing to applicants or policyholders that insurance is free or without cost for any period of time.
- Restores the contestability statute, s. 626.99287, F.S., and amends it to include the new 5-year incontestability period and exceptions in the original bill's s. 626.99275, F.S. (prohibited practices; penalties), clarifies an existing exception, and
- Makes conforming changes to cross-references.

This analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.

1 A bill to be entitled
2 An act relating to viatical settlements; amending s.
3 626.9911, F.S.; revising definitions; defining the
4 terms "business of viatical settlements," "fraudulent
5 viatical settlement act," and "stranger-originated
6 life insurance practice"; amending s. 626.9913, F.S.;
7 requiring additional information in an annual
8 statement filed by viatical settlement provider
9 licensees; revising deposit requirements for viatical
10 settlement provider licensees; deleting an obsolete
11 provision regarding a deposit requirement; authorizing
12 the Financial Services Commission to adopt rules;
13 amending s. 626.9914, F.S.; adding an act that
14 warrants the imposition of administrative penalties
15 against viatical settlement provider licensees;
16 increasing the amount of administrative fines that may
17 be imposed by the Office of Insurance Regulation
18 against licensees for certain violations; amending s.
19 626.99175, F.S.; deleting an obsolete provision;
20 deleting an exception from registration requirements
21 for life expectancy providers; creating s. 626.99185,
22 F.S.; requiring viatical settlement providers to
23 provide viators with a disclosure statement before or
24 concurrently with a viator's execution of a viatical
25 settlement contract; providing requirements and
26 procedures for such disclosure statements; amending s.

27 626.9924, F.S.; correcting cross-references relating
28 to a requirement to provide specified documents with a
29 notice that a policy has or will become a viaticated
30 policy; amending s. 626.99245, F.S.; conforming a
31 cross-reference; creating s. 626.99273, F.S.;
32 prohibiting certain practices and conflicts of
33 interest relating to viatical settlement contracts or
34 insurance policies; requiring a viatical settlement
35 provider to file certain promotional, advertising, and
36 marketing materials with the office before entering
37 into viatical settlement contracts; prohibiting
38 certain references relating to the cost of life
39 insurance policies in such materials and other
40 specified statements and representations; authorizing
41 the commission to adopt rules; amending s. 626.99275,
42 F.S.; prohibiting a person from entering into a
43 viatical settlement contract before a specified date
44 except under specified circumstances, from issuing,
45 soliciting, marketing, or otherwise promoting the
46 purchase of a policy under certain circumstances, and
47 from engaging in a fraudulent viatical settlement act;
48 providing criminal penalties for a violation of such
49 prohibitions; creating s. 626.99276, F.S.; requiring
50 specified affidavits and other documentation to be
51 provided to an insurer for requests to verify coverage
52 and to transfer a policy or certificate to a viatical

53 settlement provider; prohibiting insurers from
54 requiring certain forms that have not been approved by
55 the office to be signed as a condition of responding
56 to such requests; requiring insurers to respond in
57 writing during a specified period to properly
58 completed requests to change the ownership or
59 beneficiary of a policy; amending s. 626.99278, F.S.;
60 providing requirements for licensed viatical
61 settlement providers to maintain specified
62 documentation relating to anti-fraud plans and
63 procedures, material inconsistencies between medical
64 records and insurance applications, and reporting of
65 specified fraudulent acts and prohibited practices;
66 amending s. 626.99287, F.S.; revising the period
67 during which certain viatical settlement contracts are
68 void and unenforeceable; revising exceptions to such
69 contracts being void and unenforceable; creating s.
70 626.99289, F.S.; providing that certain contracts,
71 agreements, arrangements, and transactions relating to
72 stranger-originated life insurance practices are void
73 and unenforceable; providing an effective date.
74
75 Be It Enacted by the Legislature of the State of Florida:
76
77 Section 1. Section 626.9911, Florida Statutes, is amended
78 to read:

79 626.9911 Definitions.—As used in this act, the term:
80 (1) "Business of viatical settlements" means an activity
81 involved in the offering, soliciting, negotiating, procuring,
82 effectuating, purchasing, investing, monitoring, tracking,
83 underwriting, selling, transferring, assigning, pledging, or
84 hypothecating of, or acquiring in other manner, an interest in a
85 life insurance policy by means of a viatical settlement
86 contract.
87 (2) "Financing entity" means an underwriter, placement
88 agent, lender, purchaser of securities, or purchaser of a policy
89 or certificate from a viatical settlement provider, credit
90 enhancer, or any entity that has direct ownership in a policy or
91 certificate that is the subject of a viatical settlement
92 contract, but whose principal activity related to the
93 transaction is providing funds or credit enhancement to effect
94 the viatical settlement or the purchase of one or more
95 viaticated policies and who has an agreement in writing with one
96 or more licensed viatical settlement providers to finance the
97 acquisition of viatical settlement contracts. The term does not
98 include a nonaccredited investor or other natural person. A
99 financing entity may not enter into a viatical settlement
100 contract.
101 (3) "Fraudulent viatical settlement act" means an act or
102 omission committed by a person who, knowingly or with the intent
103 to defraud for the purpose of depriving another of property or
104 for pecuniary gain, commits or allows an employee or agent to

105 commit an act specified in this subsection.
106 (a) Presenting, causing to be presented, or preparing with
107 the knowledge or belief that it will be presented to or by
108 another person false or concealed material information as part
109 of, in support of, or concerning a fact material to:
110 1. An application for the issuance of a viatical
111 settlement contract or an insurance policy;
112 2. The underwriting of a viatical settlement contract or
113 an insurance policy;
114 3. A claim for payment or benefit pursuant to a viatical
115 settlement contract or an insurance policy;
116 4. Premiums paid on an insurance policy;
117 5. Payments and changes in ownership or beneficiary made
118 in accordance with the terms of a viatical settlement contract
119 or an insurance policy;
120 6. The reinstatement or conversion of an insurance policy;
121 7. The solicitation, offer, effectuation, or sale of a
122 viatical settlement contract or an insurance policy;
123 8. The issuance of written evidence of a viatical
124 settlement contract or an insurance policy; or
125 9. A financing transaction.
126 (b) Employing a plan, financial structure, device, scheme,
127 or artifice to defraud related to viaticated policies.
128 (c) Engaging in a stranger-originated life insurance
129 practice.
130 (d) Failing to disclose upon request by an insurer that

131 the prospective insured has undergone a life expectancy
132 evaluation by a person other than the insurer or its authorized
133 representatives in connection with the issuance of the policy.
134 (e) Perpetuating a fraud or preventing the detection of a
135 fraud by:
136 1. Removing, concealing, altering, destroying, or
137 sequestering from the office the assets or records of a licensee
138 or other person engaged in the business of viatical settlements;
139 2. Misrepresenting or concealing the financial condition
140 of a licensee, financing entity, insurer, or other person;
141 3. Transacting in the business of viatical settlements in
142 violation of laws requiring a license, certificate of authority,
143 or other legal authority to transact such business; or
144 4. Filing with the office or the equivalent chief
145 insurance regulatory official of another jurisdiction a document
146 that contains false information or conceals information about a
147 material fact from the office or other regulatory official.
148 (f) Embezzlement, theft, misappropriation, or conversion
149 of moneys, funds, premiums, credits, or other property of a
150 viatical settlement provider, insurer, insured, viator,
151 insurance policyowner, or other person engaged in the business
152 of viatical settlements or insurance.
153 (g) Recklessly entering into, negotiating, brokering, or
154 otherwise dealing in a viatical settlement contract, the subject
155 of which is a life insurance policy that was obtained based on
156 information that was falsified or concealed for the purpose of

157 defrauding the policy's issuer, viatical settlement provider, or
158 viator. As used in this paragraph, the term "recklessly" means
159 acting or failing to act in conscious disregard for the relevant
160 facts or risks, and which disregard involves a gross deviation
161 from acceptable standards of conduct.
162 (h) Facilitating the viator's change of residency state to
163 avoid the provisions of this act.
164 (i) Facilitating or causing the creation of a trust with a
165 non-Florida situs or other nonresident entity for the purpose of
166 owning a life insurance policy covering a Florida resident to
167 avoid the provisions of this act.
168 (j) Facilitating or causing the transfer of the ownership
169 of an insurance policy covering a Florida resident to a trust
170 with a non-Florida situs or other nonresident entity to avoid
171 the provisions of this act.
172 (k) Applying for or obtaining a loan that is secured
173 directly or indirectly by an interest in a life insurance
174 policy.
175 (l) Violating s. 626.99273(1) or (2).
176 (m) Attempting to commit, assisting, aiding, or abetting
177 in the commission of or conspiring to commit an act or omission
178 specified in this subsection.
179 (4) ~~(2)~~ "Independent third-party trustee or escrow agent"
180 means an attorney, certified public accountant, financial
181 institution, or other person providing escrow services under the
182 authority of a regulatory body. The term does not include any

183 person associated, affiliated, or under common control with a
184 viatical settlement provider or viatical settlement broker.
185 (5)~~(3)~~ "Life expectancy" means an opinion or evaluation as
186 to how long a particular person is to live, or relating to such
187 person's expected demise.
188 (6)~~(4)~~ "Life expectancy provider" means a person who
189 determines, or holds himself or herself out as determining, life
190 expectancies or mortality ratings used to determine life
191 expectancies under any of the following circumstances:
192 (a) On behalf of a viatical settlement provider, viatical
193 settlement broker, life agent, or person engaged in the business
194 of viatical settlements.~~;~~
195 (b) In connection with a viatical settlement investment,
196 pursuant to s. 517.021(24).~~; or~~
197 (c) On residents of this state in connection with a
198 viatical settlement contract or viatical settlement investment.
199 (7)~~(5)~~ "Person" has the meaning specified in s. 1.01.
200 (8)~~(6)~~ "Related form" means any form, created by or on
201 behalf of a licensee, which a viator or insured is required to
202 sign or initial. The forms include, but are not limited to, a
203 power of attorney, a release of medical information form, a
204 suitability questionnaire, a disclosure document, or any
205 addendum, schedule, or amendment to a viatical settlement
206 contract considered necessary by a provider to effectuate a
207 viatical settlement transaction.
208 (9)~~(7)~~ "Related provider trust" means a titling trust or

209 other trust established by a licensed viatical settlement
210 provider or financing entity for the sole purpose of holding the
211 ownership or beneficial interest in purchased policies in
212 connection with a financing transaction. The trust must have a
213 written agreement with a licensed viatical settlement provider
214 or financing entity under which the licensed viatical settlement
215 provider or financing entity is responsible for insuring
216 compliance with all statutory and regulatory requirements and
217 under which the trust agrees to make all records and files
218 relating to viatical settlement transactions available to the
219 office as if those records and files were maintained directly by
220 the licensed viatical settlement provider. This term does not
221 include an independent third-party trustee or escrow agent or a
222 trust that does not enter into agreements with a viator. A
223 related provider trust is ~~shall be~~ subject to all provisions of
224 this act that apply to the viatical settlement provider who
225 established the related provider trust, except s. 626.9912,
226 which does ~~shall~~ not apply ~~be applicable~~. A viatical settlement
227 provider may establish up to ~~no more than~~ one related provider
228 trust, and the sole trustee of such related provider trust shall
229 be the viatical settlement provider licensed under s. 626.9912.
230 The name of the licensed viatical settlement provider shall be
231 included within the name of the related provider trust.
232 (10) ~~(8)~~ "Special purpose entity" means an entity
233 established by a licensed viatical settlement provider or by a
234 financing entity, which may be a corporation, partnership,

235 trust, limited liability company, or other similar entity formed
236 solely to provide, either directly or indirectly, access to
237 institutional capital markets to a viatical settlement provider
238 or financing entity. A special purpose entity may not obtain
239 capital from any natural person or entity with less than $50
240 million in assets and may not enter into a viatical settlement
241 contract.
242 (11) "Stranger-originated life insurance practice" means
243 an act, practice, arrangement, or agreement to initiate a life
244 insurance policy for the benefit of a third-party investor who,
245 at the time of policy origination, has no insurable interest in
246 the insured. Stranger-originated life insurance practices
247 include, but are not limited to:
248 (a) The purchase of a life insurance policy with resources
249 or guarantees from or through a person who, at the time of such
250 policy's inception, could not lawfully initiate the policy and
251 the execution of a verbal or written arrangement or agreement to
252 directly or indirectly transfer the ownership of such policy or
253 policy benefits to a third party.
254 (b) The creation of a trust or other entity that has the
255 appearance of an insurable interest to initiate policies for
256 investors, which violates insurable interest laws and the
257 prohibition against wagering on life.
258 (12) ~~(9)~~ "Viatical settlement broker" means a person who,
259 on behalf of a viator and for a fee, commission, or other
260 valuable consideration, offers or attempts to negotiate viatical

261 settlement contracts between a viator resident in this state and
262 one or more viatical settlement providers. Notwithstanding the
263 manner in which the viatical settlement broker is compensated, a
264 viatical settlement broker is deemed to represent only the
265 viator and owes a fiduciary duty to the viator to act according
266 to the viator's instructions and in the best interest of the
267 viator. The term does not include an attorney, licensed
268 Certified Public Accountant, or investment adviser lawfully
269 registered under chapter 517, who is retained to represent the
270 viator and whose compensation is paid directly by or at the
271 direction and on behalf of the viator.
272 (13) ~~(10)~~ "Viatical settlement contract" means a written
273 agreement entered into between a viatical settlement provider,
274 or its related provider trust, and a viator. The viatical
275 settlement contract includes an agreement to transfer ownership
276 or change the beneficiary designation of a life insurance policy
277 at a later date, regardless of the date that compensation is
278 paid to the viator. The agreement must establish the terms under
279 which the viatical settlement provider will pay compensation or
280 anything of value, which compensation or value is less than the
281 expected death benefit of the insurance policy or certificate,
282 in return for the viator's assignment, transfer, sale, devise,
283 or bequest of the death benefit or ownership of all or a portion
284 of the insurance policy or certificate of insurance to the
285 viatical settlement provider. The term also includes the
286 transfer for compensation or value of an ownership or a

287 beneficial interest in a trust or other entity that owns such
288 policy if the trust or other entity was formed or used for the
289 principal purpose of acquiring one or more life insurance
290 contracts that insure the life of a person residing in this
291 state, and ~~A viatical settlement contract also includes~~ a
292 contract for a loan or other financial transaction secured
293 primarily by an individual or group life insurance policy. The
294 term does not include~~, other than~~ a policy loan by a life
295 insurance company pursuant to the terms of the life insurance
296 contract or accelerated death provisions contained in a life
297 insurance policy, whether issued with the original policy or as
298 a rider, ~~or~~ a loan secured by the cash surrender value of a
299 policy as determined by the policy issuer and the life insurance
300 policy terms, or a loan or advance from the issuer of the policy
301 to the policyowner.
302 (14)~~(11)~~ "Viatical settlement investment" has the same
303 meaning as specified in s. 517.021.
304 (15)~~(12)~~ "Viatical settlement provider" means a person
305 who, in this state, from this state, or with a resident of this
306 state, effectuates a viatical settlement contract. The term does
307 not include:
308 (a) A ~~Any~~ bank, savings bank, savings and loan
309 association, or credit union~~, or other licensed lending~~
310 ~~institution~~ that takes an assignment of a life insurance policy
311 as collateral for a loan.
312 (b) A life and health insurer that has lawfully issued a

313 life insurance policy that provides accelerated benefits to
314 terminally ill policyholders or certificateholders.
315 (c) A ~~Any~~ natural person who enters into no more than one
316 viatical settlement contract with a viator in 1 calendar year,
317 unless such natural person has previously been licensed under
318 this act or is currently licensed under this act.
319 (d) A trust that meets the definition of a "related
320 provider trust."
321 (e) A viator in this state.
322 (f) A financing entity.
323 (16) ~~(13)~~ "Viaticated policy" means a life insurance
324 policy, or a certificate under a group policy, which is the
325 subject of a viatical settlement contract.
326 (17) ~~(14)~~ "Viator" means the owner of a life insurance
327 policy or a certificateholder under a group policy, which policy
328 is not a previously viaticated policy, who enters or seeks to
329 enter into a viatical settlement contract. This term does not
330 include a viatical settlement provider, ~~or~~ a ~~any~~ person
331 acquiring a policy or interest in a policy from a viatical
332 settlement provider, or ~~nor does it include~~ an independent
333 third-party trustee or escrow agent.
334 Section 2. Subsections (2) and (3) of section 626.9913,
335 Florida Statutes, are amended, and subsection (6) is added to
336 that section, to read:
337 626.9913 Viatical settlement provider license continuance;
338 annual report; fees; deposit.—

339 (2)(a) Annually, on or before March 1, the viatical
340 settlement provider licensee shall file a statement containing
341 information the commission requires and shall pay to the office
342 a license fee in the amount of $500.
343 (b) In addition to any other requirements, the annual
344 statement must specify:
345 1. The total number of unsettled viatical settlement
346 contracts and corresponding total amount due to viators under
347 viatical settlement contracts that have been signed by the
348 viator but have not been settled as of December 31 of the
349 preceding calendar year, categorized by the number of days since
350 the viator signed the contract for transactions regulated by
351 this state.
352 2. For each of the most recent 5 years, the total number
353 of policies purchased, total gross amount paid for policies
354 purchased, total commissions or compensation paid for policies
355 purchased, and total face value of policies purchased, allocated
356 by state, territory, and jurisdiction.
357 3. For the most recent calendar year, the total amount of
358 proceeds or compensation paid to policyowners, allocated by
359 state, territory, and jurisdiction.
360 (c) ~~After December 31, 2007,~~ The annual statement shall
361 include an annual audited financial statement of the viatical
362 settlement provider prepared in accordance with generally
363 accepted accounting principles by an independent certified
364 public accountant covering a 12-month period ending on a day

365 occurring within ~~falling during~~ the last 6 months of the
366 preceding calendar year. If the audited financial statement has
367 not been completed, however, the licensee shall include in its
368 annual statement an unaudited financial statement for the
369 preceding calendar year and an affidavit from an officer of the
370 licensee stating that the audit has not been completed. In this
371 event, the licensee shall submit the audited statement on or
372 before June 1. The annual statement, due on or before March 1
373 each year, shall also provide the office with a report of all
374 life expectancy providers who have provided life expectancies
375 directly or indirectly to the viatical settlement provider for
376 use in connection with a viatical settlement contract or a
377 viatical settlement investment. A viatical settlement provider
378 shall include in all statements filed with the office all
379 information requested by the office regarding a related provider
380 trust established by the viatical settlement provider. The
381 office may require more frequent reporting. Failure to timely
382 file the annual statement or the audited financial statement or
383 to timely pay the license fee is grounds for immediate
384 suspension of the license. The commission may by rule require
385 all or part of the statements or filings required under this
386 section to be submitted by electronic means in a computer-
387 readable form compatible with the electronic data format
388 specified by the commission.
389 (3) To ensure the faithful performance of its obligations
390 to its viators in the event of insolvency or the loss of its

391 license, a viatical settlement provider licensee must deposit
392 and maintain deposited in trust with the department securities
393 eligible for deposit under s. 625.52, having at all times a
394 value of not less than $250,000 ~~$100,000; however, a viatical~~
395 ~~settlement provider licensed in this state prior to June 1,~~
396 ~~2004, which has deposited and maintains continuously deposited~~
397 ~~in trust with the department securities in the amount of $25,000~~
398 ~~and which posted and maintains continuously posted a security~~
399 ~~bond acceptable to the department in the amount of $75,000, has~~
400 ~~until June 1, 2005, to comply with the requirements of this~~
401 ~~subsection~~.
402 (6) The commission may adopt rules to implement this
403 section.
404 Section 3. Subsections (1) and (2) of section 626.9914,
405 Florida Statutes, are amended to read:
406 626.9914 Suspension, revocation, denial, or nonrenewal of
407 viatical settlement provider license; grounds; administrative
408 fine.—
409 (1) The office shall suspend, revoke, deny, or refuse to
410 renew the license of any viatical settlement provider if the
411 office finds that the licensee has committed any of the
412 following acts:
413 (a) Has made a misrepresentation in the application for
414 the license.~~;~~
415 (b) Has engaged in fraudulent or dishonest practices, or
416 otherwise has been shown to be untrustworthy or incompetent to

417 act as a viatical settlement provider.~~;~~
418 (c) Demonstrates a pattern of unreasonable payments to
419 viators.~~;~~
420 (d) Has been found guilty of, or has pleaded guilty or
421 nolo contendere to, any felony, or a misdemeanor involving fraud
422 or moral turpitude, regardless of whether a judgment of
423 conviction has been entered by the court.~~;~~
424 (e) Has issued viatical settlement contracts that have not
425 been approved pursuant to this act.~~;~~
426 (f) Has failed to honor contractual obligations related to
427 the business of viatical settlement contracts.~~;~~
428 (g) Deals in bad faith with viators.~~;~~
429 (h) Has violated any provision of the insurance code or of
430 this act.~~;~~
431 (i) Employs or contracts with a ~~any~~ person who materially
432 influences the licensee's conduct and who fails to meet the
433 requirements of this act.~~;~~
434 (j) No longer meets the requirements for initial
435 licensure.~~; or~~
436 (k) Obtains or utilizes life expectancies from life
437 expectancy providers who are not registered with the office
438 pursuant to this act.
439 (l) Has engaged in a fraudulent viatical settlement act.
440 (2) The office may, in lieu of or in addition to any
441 suspension or revocation, assess an administrative fine not to
442 exceed $10,000 ~~$2,500~~ for each nonwillful violation or $25,000

443 ~~$10,000~~ for each willful violation by a viatical settlement
444 provider licensee. The office may also place a viatical
445 settlement provider licensee on probation for a period not to
446 exceed 2 years.
447 Section 4. Subsection (1) of section 626.99175, Florida
448 Statutes, is amended to read:
449 626.99175 Life expectancy providers; registration
450 required; denial, suspension, revocation.—
451 (1) ~~After July 1, 2006,~~ A person may not perform the
452 functions of a life expectancy provider without first having
453 registered as a life expectancy provider~~, except as provided in~~
454 ~~subsection (6)~~.
455 Section 5. Section 626.99185, Florida Statutes, is created
456 to read:
457 626.99185 Disclosures to viator of disbursement.—
458 (1) Before or concurrently with a viator's execution of a
459 viatical settlement contract, the viatical settlement provider
460 shall provide to the viator, in duplicate, a disclosure
461 statement in legible written form disclosing:
462 (a) The name of each viatical settlement broker who
463 receives or will receive compensation and the amount of each
464 broker's compensation related to that transaction. For the
465 purpose of this section, compensation includes anything of value
466 paid or given by or at the direction of a viatical settlement
467 provider or person acquiring an interest in one or more life
468 insurance policies to a viatical settlement broker in connection

469 with the viatical settlement contract.
470 (b) A complete reconciliation of the gross offer or bid by
471 the viatical settlement provider to the net amount of proceeds
472 or value to be received by the viator related to that
473 transaction. As used in this section, the term "gross offer" or
474 "bid" means the total amount or value offered by the viatical
475 settlement provider for the purchase of an interest in one or
476 more life insurance policies, including commissions,
477 compensation, or other proceeds or value being deducted from the
478 gross offer or bid.
479 (2) The viator shall sign and date the disclosure
480 statement before or concurrently with the viator's execution of
481 a viatical settlement contract, with the viator retaining the
482 duplicate copy of the disclosure statement.
483 (3) If a viatical settlement contract is entered into and
484 the contract is subsequently amended or if there is a change in
485 the viatical settlement provider's gross offer or bid amount, a
486 change in the net amount of proceeds or value to be received by
487 the viator, or a change in the information provided in the
488 disclosure statement to the viator, the viatical settlement
489 provider shall provide, in duplicate, an amended disclosure
490 statement to the viator containing the information in subsection
491 (1). The viator shall sign and date the amended disclosure
492 statement, with the viator retaining the duplicate copy of the
493 amended disclosure statement.
494 (4) Before a viatical settlement provider's execution of a

495 viatical settlement contract or an amendment to such contract,
496 the viatical settlement provider must obtain the signed and
497 dated disclosure statement and any amended disclosure statement
498 required by this section. In transactions for which a broker is
499 not used, the viatical settlement provider must obtain the
500 signed and dated disclosure statement from the viator.
501 (5) The viatical settlement provider shall maintain the
502 documentation required by this section pursuant to s.
503 626.9922(2) and shall make such documentation available to the
504 office at any time for copying and inspection upon reasonable
505 notice by the office to the viatical settlement provider.
506 Section 6. Subsection (7) of section 626.9924, Florida
507 Statutes, is amended to read:
508 626.9924 Viatical settlement contracts; procedures;
509 rescission.—
510 (7) At any time during the contestable period, within 20
511 days after a viator executes documents necessary to transfer
512 rights under an insurance policy or within 20 days of any
513 agreement, option, promise, or any other form of understanding,
514 express or implied, to viaticate the policy, the provider must
515 give notice to the insurer of the policy that the policy has or
516 will become a viaticated policy. The notice must be accompanied
517 by the documents required by ss. 626.99276 and 626.99287 ~~s.~~
518 ~~626.99287(5)(a)~~ in their entirety.
519 Section 7. Subsection (2) of section 626.99245, Florida
520 Statutes, is amended to read:

521 626.99245 Conflict of regulation of viaticals.—
522 (2) This section does not affect the requirement of ss.
523 626.9911(15) ~~(12)~~ and 626.9912(1) that a viatical settlement
524 provider doing business from this state must obtain a viatical
525 settlement license from the office. As used in this subsection,
526 the term "doing business from this state" includes effectuating
527 viatical settlement contracts from offices in this state,
528 regardless of the state of residence of the viator.
529 Section 8. Section 626.99273, Florida Statutes, is created
530 to read:
531 626.99273 Prohibited practices and conflicts of interest.—
532 (1) With respect to a viatical settlement contract or an
533 insurance policy, a viatical settlement broker may not knowingly
534 solicit an offer from, effectuate a viatical settlement with, or
535 make a sale to any viatical settlement provider, financing
536 entity, or related provider trust that is controlling,
537 controlled by, or under common control with such viatical
538 settlement broker.
539 (2) With respect to a viatical settlement contract or an
540 insurance policy, a viatical settlement provider may not
541 knowingly enter into a viatical settlement contract with a
542 viator if, in connection with such viatical settlement contract,
543 anything of value will be paid to a viatical settlement broker
544 that is controlling, controlled by, or under common control with
545 such viatical settlement provider, financing entity, or related
546 provider trust that is involved in such viatical settlement

547 contract.
548 (3) A viatical settlement provider may not enter into a
549 viatical settlement contract unless the viatical settlement
550 promotional, advertising, and marketing materials, as may be
551 prescribed by rule, have been filed with the office. Such
552 materials may not expressly indicate, or include any reference
553 that would cause a viator to reasonably believe, that the life
554 insurance is free for any period of time.
555 (4) A life insurance agent, insurer, viatical settlement
556 broker, or viatical settlement provider may not make a statement
557 or representation to an applicant or policyholder in connection
558 with the sale of a life insurance policy to the effect that the
559 insurance is free or without cost to the policyholder for any
560 period of time.
561 (5) The commission may adopt rules to implement this
562 section.
563 Section 9. Section 626.99275, Florida Statutes, is amended
564 to read:
565 626.99275 Prohibited practices; penalties.—
566 (1) It is unlawful for a ~~any~~ person to:
567 (a) ~~To~~ Knowingly enter into, broker, or otherwise deal in
568 a viatical settlement contract the subject of which is a life
569 insurance policy, knowing that the policy was obtained by
570 presenting materially false information concerning any fact
571 material to the policy or by concealing, for the purpose of
572 misleading another, information concerning any fact material to

573 the policy, where the viator or the viator's agent intended to
574 defraud the policy's issuer.
575 (b) ~~To~~ Knowingly or with the intent to defraud, for the
576 purpose of depriving another of property or for pecuniary gain,
577 issue or use a pattern of false, misleading, or deceptive life
578 expectancies.
579 (c) ~~To~~ Knowingly engage in any transaction, practice, or
580 course of business intending thereby to avoid the notice
581 requirements of s. 626.9924(7).
582 (d) ~~To~~ Knowingly or intentionally facilitate the change of
583 state of residency of a viator to avoid the provisions of this
584 chapter.
585 (e) Knowingly enter into a viatical settlement contract
586 before the application for or issuance of a life insurance
587 policy that is the subject of a viatical settlement contract or
588 during the 5-year period commencing on the date of issuance of
589 the policy or certificate, unless the viator provides a sworn
590 affidavit and accompanying documentation in accordance with s.
591 626.9987.
592 (f) Knowingly issue, solicit, market, or otherwise promote
593 the purchase of a life insurance policy for the purpose of or
594 with an emphasis on selling the policy.
595 (g) Engage in a fraudulent viatical settlement act.
596 (2) A person who violates any provision of this section
597 commits:
598 (a) A felony of the third degree, punishable as provided

599 in s. 775.082, s. 775.083, or s. 775.084, if the insurance
600 policy involved is valued at any amount less than $20,000.
601 (b) A felony of the second degree, punishable as provided
602 in s. 775.082, s. 775.083, or s. 775.084, if the insurance
603 policy involved is valued at $20,000 or more, but less than
604 $100,000.
605 (c) A felony of the first degree, punishable as provided
606 in s. 775.082, s. 775.083, or s. 775.084, if the insurance
607 policy involved is valued at $100,000 or more.
608 Section 10. Section 626.99276, Florida Statutes, is
609 created to read:
610 626.99276 Notification to insurer required.—
611 (1) A copy of the sworn affidavit and the documentation
612 required in s. 626.99287 must be submitted to the insurer if the
613 viatical settlement provider or other party entering into a
614 viatical settlement contract with a viator submits a request to
615 the insurer for verification of coverage or if the viatical
616 settlement provider submits a request to transfer the policy or
617 certificate to the provider. If the request is made by a
618 viatical settlement provider, the copy shall be accompanied by a
619 sworn affidavit from the viatical settlement provider affirming
620 that the copy is a true and correct copy of the documentation
621 received by the provider.
622 (2) An insurer may not require, as a condition of
623 responding to a request for verification of coverage or
624 effecting the transfer of a policy pursuant to a viatical

625 settlement contract, that the viator, insured, viatical
626 settlement provider, or viatical settlement broker sign any
627 disclosures, consent form, waiver form, or other form that has
628 not been approved by the office for use in connection with
629 viatical settlement contracts in this state.
630 (3) Upon receipt of a properly completed request for
631 change of ownership or beneficiary of a policy, the insurer
632 shall respond in writing within 30 calendar days confirming that
633 the change has been effectuated or specifying the reasons why
634 the requested change cannot be processed. The insurer may not
635 unreasonably delay effectuating a change of ownership or
636 beneficiary and may not otherwise seek to interfere with any
637 viatical settlement contract lawfully entered into in this
638 state.
639 Section 11. Section 626.99278, Florida Statutes, is
640 amended to read:
641 626.99278 Viatical provider anti-fraud plan.—
642 (1) Each ~~Every~~ licensed viatical settlement provider and
643 registered life expectancy provider must adopt an anti-fraud
644 plan and file it with the Division of Insurance Fraud of the
645 department. Each anti-fraud plan shall include:
646 (a) ~~(1)~~ A description of the procedures for detecting and
647 investigating possible fraudulent acts and procedures for
648 resolving material inconsistencies between medical records and
649 insurance applications.
650 (b) ~~(2)~~ A description of the procedures for the mandatory

651 reporting of possible fraudulent insurance acts and prohibited
652 practices specified ~~set forth~~ in s. 626.99275 to the Division of
653 Insurance Fraud ~~of the department~~.
654 (c) ~~(3)~~ A description of the plan for anti-fraud education
655 and training of its underwriters or other personnel.
656 (d) ~~(4)~~ A written description or chart outlining the
657 organizational arrangement of the anti-fraud personnel who are
658 responsible for the investigation and reporting of possible
659 fraudulent insurance acts and for the investigation of
660 unresolved material inconsistencies between medical records and
661 insurance applications.
662 (e) ~~(5)~~ For viatical settlement providers, a description of
663 the procedures used to perform initial and continuing review of
664 the accuracy of life expectancies used in connection with a
665 viatical settlement contract or viatical settlement investment.
666 (2) Each licensed viatical settlement provider shall
667 maintain in accordance with s. 626.9922:
668 (a) Documentation of compliance with its anti-fraud plan
669 and procedures filed in accordance with this section.
670 (b) Documentation pertaining to resolved and unresolved
671 material inconsistencies between medical records and insurance
672 applications.
673 (c) Documentation of its mandatory reporting of the
674 possible fraudulent acts and prohibited practices specified in
675 s. 626.99275 to the Division of Insurance Fraud.
676 Section 12. Section 626.99287, Florida Statutes, is

677 amended, to read:
678 626.99287 Contestability of viaticated policies.—Except as
679 hereinafter provided, if a viatical settlement contract is
680 entered into during ~~within~~ the 5-year ~~2-year~~ period commencing
681 on ~~with~~ the date of issuance of the insurance policy or
682 certificate to be acquired, the viatical settlement contract is
683 void and unenforceable by either party. Notwithstanding this
684 limitation, such a viatical settlement contract is not void and
685 unenforceable if the viator provides a sworn affidavit and
686 accompanying documentation that certifies to the viatical
687 settlement provider that one or more of the following conditions
688 were met during the 5-year period:
689 (1) The policy was issued upon the owner's exercise of
690 conversion rights arising out of a group or term policy, if the
691 total time covered under the prior policy is at least 60 months.
692 The time covered under a group policy shall be calculated
693 without regard to any change in insurance carriers, provided the
694 coverage has been continuous and under the same group
695 sponsorship;
696 (2) The owner of the policy is a charitable organization
697 exempt from taxation under 26 U.S.C. s. 501(c)(3);
698 (3) The owner of the policy is not a natural person;
699 (4) The viatical settlement contract was entered into
700 before July 1, 2000;
701 (5) The viator certifies by producing independent evidence
702 to the viatical settlement provider that one or more of the

703 following conditions were ~~have been~~ met during ~~within~~ the 5-year
704 ~~2-year~~ period:
705 (a)~~1.~~ The viator or insured is terminally or chronically
706 ill ~~diagnosed with an illness or condition that is either:~~
707 ~~a. Catastrophic or life threatening; or~~
708 ~~b. Requires a course of treatment for a period of at least~~
709 ~~3 years of long-term care or home health care;~~ and
710 ~~2.~~ the condition was not known to the insured at the time
711 the life insurance contract was entered into;~~.~~
712 (b) The viator's spouse dies;
713 (c) The viator divorces his or her spouse;
714 (d) The viator retires from full-time employment;
715 (e) The viator becomes physically or mentally disabled and
716 a physician determines that the disability prevents the viator
717 from maintaining full-time employment;
718 (f) The owner of the policy was the insured's employer at
719 the time the policy or certificate was issued and the employment
720 relationship terminated;
721 (g) A final order, judgment, or decree is entered by a
722 court of competent jurisdiction, on the application of a
723 creditor of the viator, adjudicating the viator bankrupt or
724 insolvent, or approving a petition seeking reorganization of the
725 viator or appointing a receiver, trustee, or liquidator to all
726 or a substantial part of the viator's assets; or
727 (h) The viator experiences a significant decrease in
728 income which is unexpected by the viator and which impairs his

729 or her reasonable ability to pay the policy premium.
730 (6) The viator entered into a viatical settlement contract
731 more than 2 years after the policy's issuance date and, with
732 respect to the policy, at all times before such date each of the
733 following conditions were met:
734 (a) Policy premiums were funded exclusively with
735 unencumbered assets, including an interest in the life insurance
736 policy being financed but only to the extent of its net cash
737 surrender value provided by or full recourse liability incurred
738 by the insured;
739 (b) An agreement or understanding with another person was
740 not entered into to guarantee any such liability or to purchase,
741 or agree to purchase, the policy, including through an
742 assumption or forgiveness of the loan; and
743 (c) The insured and the policy were not evaluated for
744 settlement.
745
746 ~~If the viatical settlement provider submits to the insurer a~~
747 ~~copy of the viator's or owner's certification described above,~~
748 ~~then the provider submits a request to the insurer to effect the~~
749 ~~transfer of the policy or certificate to the viatical settlement~~
750 ~~provider, the viatical settlement agreement shall not be void or~~
751 ~~unenforceable by operation of this section. The insurer shall~~
752 ~~timely respond to such request. Nothing in this section shall~~
753 ~~prohibit an insurer from exercising its right during the~~
754 ~~contestability period to contest the validity of any policy on~~

755 ~~grounds of fraud.~~
756 Section 13. Section 626.99289, Florida Statutes, is
757 created to read:
758 626.99289 Void and unenforceable contracts, agreements,
759 arrangements, and transactions.—A contract, agreement,
760 arrangement, or transaction, including, but not limited to, a
761 financing agreement or any other arrangement or understanding
762 entered into, whether written or verbal, for the furtherance or
763 aid of a stranger-originated life insurance practice is void and
764 unenforceable.
765 Section 14. This act shall take effect July 1, 2016.

HB 461

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 461 Location of Utilities
SPONSOR(S): Ingram, Campbell and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 416

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Local Government Affairs Subcommittee	12 Y, 0 N	Darden	Miller
2) Appropriations Committee		Proctor	Leznoff

SUMMARY ANALYSIS

Consistent with common law, Florida Statutes provides for a utility to bear the costs of relocating its facilities located "upon, under, over, or along" any public road or rail corridor if the facilities "unreasonably interfere in any way with the convenient, safe, or continuous use, or the maintenance, improvement, extension, or expansion" of the road or rail corridor. There are nine exceptions to this general rule enumerated by statute.

The bill would provide an additional exemption to the general rule requiring utilities to bear the cost for relocating their facilities. The bill requires the Department of Transportation (DOT) or the local government entity to pay for the relocation of utility facilities if the facilities are located within an existing and valid public utility easement granted by recorded plat. This exception would still apply if ownership of the underlying land was acquired by the governmental entity requiring the relocation. Under this exception, the governmental entity would be required to pay the full cost of relocation, after deductions for any increase in value attributable to the new facility and any salvage value of the old facility.

The bill limits the authority of the county to grant licenses for utility facilities to only those facilities located "under, on, over, across, or within the right-of-way limits of," but not "along," a county highway or public road or highway.

The bill limits the authority of DOT and local government entities to prescribe and enforce reasonable rules and regulations relating the placement or maintenance of utility facilities to those located "under, on, over, across, or within the right-of-way limits of," but not "along," a county highway or public road or highway.

The bill may have an indeterminate negative fiscal impact on state and local government expenditures, to the extent these entities engage in road and rail projects requiring utility relocations.

The bill is effective upon becoming law.

The municipality/county mandates provision of Art. VII, s. 18 of the Florida Constitution may apply. **If the bill does qualify as a mandate, the law must fulfill an important state interest and final passage must be approved by two-thirds of the membership of each house of the Legislature.**

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Public roads, highways, and rail corridors, as well as water, sewer, gas, power, telephone, television, and other utilities, play an essential role in our daily lives. Originally, the streets throughout our country were "laid out for the horse and buggy age" and, with time, they became "too narrow for the present traffic conditions."[1] Over time, streets were expanded to accommodate traffic and, even today, streets require expansion to accommodate evolving traffic needs. Rather than acquiring separate easements from private landowners, government authorities historically have allowed utilities to lay their lines and facilities within public rights-of-way and utility easements. Under current law regarding the platting of real property,[2] every plat offered for recording must include a dedication by all owners of record of the land to be subdivided.[3] Once a plat is recorded in compliance with the statute, all streets, rights-of-way, alleys, easements, and public areas shown on the plat are deemed dedicated for public use, for the uses and purposes thereon stated, unless otherwise stated.[4]

Historically, utilities have been required to pay to relocate lines or facilities located within property held for the public's benefit when relocation is required for a public project. For example, in 1905 the U.S. Supreme Court held that a gas utility company, which had an agreement providing it would make reasonable changes when directed by the City of New Orleans, was not entitled to be compensated for relocating certain lines located within streets and alleys in order for the city to develop a drainage system.[5] Similarly, in 1906 the Florida Supreme Court explained that it is a "rule well settled in the law [that with any] grant to individuals and corporations [of] the privilege of occupying the streets and public ways for lawful purposes, such as railroad tracks, poles, wires, and gas and water pipes, such rights are at all times held in subordination to the superior rights of the public, and all necessary and desirable police ordinances, that are reasonable, may be enacted and enforced to protect the public health, safety, and convenience, notwithstanding the same may interfere with legal franchise rights."[6]

Accordingly, in 1935, the U.S. Supreme Court held that a utility, which had purchased a right-of-way for pipes and auxiliary telephone lines, had purchased a private right-of-way, or private easement, which the court held was land subject to compensation by the authority seeking to build a highway across it.[7]

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[1] *Ridgefield Land Co. v. City of Detroit*, 217 N.W. 58, 59 (Mich. 1928).

[2] Current law provides that every plat submitted to the approving agency of a local governing body must be accompanied by a boundary survey of the platted lands, as well as a title opinion of an attorney-at-law licensed in Florida or a certification by an abstractor or a title company, as specified by statute. Section 177.041, F.S. Prior to approval by the appropriate governing body, the plat must be reviewed for conformity to the governing statutes by a professional surveyor and mapper either employed by or under contract to the local governing body, the costs of which must be borne by the legal entity offering the plat for recordation, and evidence of such review must be placed on such plat. Section 177.081(1), F.S.

[3] Section 177.081(3), F.S. As used in chapter 177, F.S., "'[e]asement' means any strip of land created by a subdivider for public or private utilities, drainage, sanitation, or other specified uses having limitations, the title to which shall remain in the name of the property owner, subject to the right of use designated in the reservation of the servitude." Section 177.031(7)(a), F.S. "'Right-of-way' means land dedicated, deeded, used, or to be used for a street, alley, walkway, boulevard, drainage facility, access for ingress and egress, or other purpose by the public, certain designated individuals, or governing bodies." Section 177.031(16), F.S.

[4] *Id.*

[5] *New Orleans Gaslight Co. v. Drainage Comm'n of New Orleans*, 197 U.S. 453, 454 (1905).

[6] *Anderson v. Fuller*, 41 So. 684, 688 (Fla. 1906).

[7] *Panhandle Eastern Pipe Line Co. v. State Highway Comm'n of Kansas*, 294 U.S. 613 (1935). *See City of Grand Prairie v. Am. Tel & Tel. Co.*, 405 F.2d 1144,1146 (5th Cir. 1969) (holding the common law rule that a utility pay for relocation did not apply where the utility facilities were located within a private easement acquired long prior to planning and laying out and construction of a street). *See Bonner v. Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc) (the Eleventh Circuit Court of Appeals has adopted all of the decisions of the former Fifth Circuit decided prior to October 1, 1981).

In 1983, the U.S. Supreme Court reaffirmed the common-law principle that a utility forced to relocate from a public right-of-way must do so at its own expense.[8]

In 2014, the Florida Second District Court of Appeal (Second DCA) ruled that the requirement for utilities to pay for relocation within a right-of-way is well established in the common law[9] and, absent another arrangement by agreement between a governmental entity and the utility, or a statute dictating otherwise, this common law principle governs.[10] This case involved a platted public utility easement, six feet or less on each side of the boundary for each home site in the subdivision, in which the electric utility had installed lines and other equipment.[11] The municipality and the utility had a franchise agreement granting the utility the right to operate its electric utility in the public easement, but the agreement did not address who would be responsible for the cost of moving the utility's equipment if the municipality required the utility to do so. The Second DCA held that the utility would bear the cost of moving a utility line located within a public utility easement to another public utility easement as part of the municipality's expansion of an existing road.[12]

Utility Use of Public Lands

Various provisions of Florida law establish the authority of utilities to place their facilities on or beside public property. Chapter 361, F.S., establishes eminent domain rights over public and private property for companies that construct, maintain, or operate public works, such as water, sewer, wastewater reuse, natural gas, and electric utilities.[13] Through eminent domain, a utility acquires the property at issue.

Other provisions of law establish the authority of telecommunications companies to place their facilities along public roads or in the public right-of-way without acquiring the property. For example, s. 362.01, F.S., authorizes any telegraph or telephone company to "erect posts, wires and other fixtures for telegraph or telephone purposes on or beside any public road or highway" provided that this does not "obstruct or interfere with the common uses of said roads and highways." Permission to occupy the streets of an incorporated city or town must be obtained by the city or town council. In addition, s. 610.104, F.S., provides that a cable or video service provider granted a statewide franchise is authorized to "construct, maintain, and operate facilities through, upon, over, and under any public right-of-way ... subject to the applicable governmental permitting."

Statutory Responsibility for Cost of Removal or Relocation of Utility Facilities

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[8] *Norfolk Redevelopment & Hous. Auth. v. Chesapeake & Potomac Tele. Co. of Va.*, 464 U.S. 30, 35 (1983).

[9] *Lee County Electric Coop., Inc. v. City of Cape Coral*, 159 So. 3d 126, 130 (Fla. 2d DCA 2014), *cert. denied*, 151 So. 3d 1226 (Fla. 2014), quoting *Norfolk Redevelopment & Hous. Auth. v. Chesapeake & Potomac Tel. Co. of Va.*, 464 U.S. 30, 35 (1983).

[10] *Id.* at 130-31.

[11] "A right-of-way is not the same thing as an easement. The term 'right-of-way' has been construed to mean ... a right of passage over the land of another.... It does not necessarily mean a legal and enforceable incorporeal [or intangible] right such as an easement." *City of Miami Beach v. Carner*, 579 So. 2d 248, 253 (Fla. 3d DCA 1991) (citation & internal quotation marks omitted). An easement gives someone else a reserved right to use property in a specified manner. *See Seminole Civic Ass'n v. Adkins*, 604 So. 2d 523, 527 (Fla. 5th DCA 1992) ("[E]asements are mere rights to make certain limited use of lands and at common law, they did not have, and in the absence of contractual provisions, do not have, obligations corollary to the easement rights."). An easement "does not involve title to or an estate in the land itself." *Estate of Johnston v. TPE Hotels, Inc.*, 719 So. 2d 22, 26 (Fla. 5th DCA 1998) (citations omitted).

[12] *Lee County Electric Coop., Inc.,* supra n. 9. In reaching this conclusion, the Second DCA distinguished *Panhandle E. Pipe Line Co.*, noting that case concerned "a private easement the utility purchased from a property owner, rather than pursuant to a franchise agreement that allows the utility to use public property." *Lee County Electric Coop., Inc.*, 159 So. 3d at 129. The Second DCA in its opinion also distinguished an earlier Second DCA case, *Pinellas County v. General Tel. Co. of Fla.*, 229 So. 2d 9 (Fla. 2d DCA 1969). In *Pinellas County*, the court determined that the county had to pay for "attempt[ing] to eliminate General Telephone's franchise and forc[ing] it to relocate its facilities." The court stated that the ruling in *Pinellas County* could not be dispositive in *Lee County* since it was both unclear whether the payment ordered by the court was for the termination of the franchise agreement or the cost of relocating utility lines, and that the court in *Pinellas County* used language suggesting the franchise agreement may have had the City of St. Petersburg to pay for the cost of relocation.

[13] *See also* s. 362.02, F.S. (telegraph and telephone companies are granted eminent domain powers to construct, maintain, and operate their lines along and upon the railroad right-of-way, provided that it does not interfere with the ordinary use of the railroad).

Since 1957, Florida law expressly has provided that in the event of widening, repair, or reconstruction of a county's public road or highway,[14] the licensee must move or remove the lines at no cost to the county.[15] In 2009, that requirement was made subject to s. 337.403(1)(e), F.S.[16] In 2014, it was made subject to an additional requirement that the county find the utility is "unreasonably interfering" with the convenient, safe, or continuous use, or the maintenance, improvement, extension, or expansion, of such public road or publicly owned rail corridor.[17]

Additionally, beginning in 1957, Florida statutorily required utilities to bear the costs of relocating a utility placed upon, under, over, or along any public road[18] that an authority[19] finds unreasonably interferes in any way with the convenient, safe, or continuous use, or the maintenance, improvement, extension, or expansion of the road.[20] In 1994, that law was amended to include utilities placed upon, under, over, or along any publicly owned rail corridor.[21] Current law requires utility owners, upon 30 days' notice, to eliminate the unreasonable interference within a reasonable time or an agreed time, at their own expense.[22] However, since 1987, numerous exceptions to the general rule that the utility bear the costs under these circumstances have been statutorily carved out.[23] These exceptions include:

- When the project is on the federal aid interstate system and federal funding is identified for at least 90 percent of the cost, DOT pays for the removal or relocation with federal funds.[24]
- When utility work is performed as part of a transportation facility construction contract, DOT may participate in those costs in an amount limited to the difference between the official estimate of all the work in the agreement plus 10 percent of the amount awarded for the utility work in the construction contract.[25]
- When utility work is performed in advance of a construction contract, DOT may participate in the cost of clearing and grubbing necessary for relocation.[26]
- If the utility being removed or relocated was initially installed to serve an authority or its tenants, or both, the authority bears the cost of the utility work but is not responsible for the cost of removal or relocation of any subsequent additions to the facility for the purpose of serving others.[27]
- If, in an agreement between the utility and an authority entered into after July 1, 2009, the utility conveys, subordinates, or relinquishes a compensable property right to the authority for the purpose of accommodating the acquisition or use of the right-of-way by the authority without the agreement expressly addressing future responsibility for cost of removal or relocation the authority bears the cost of the utility work, but nothing impairs or restricts, or may be used to interpret, the terms of any agreement entered into prior to July 1, 2009.[28]

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[14] In this context, "road" means "a way open to travel by the public, including, but not limited to, a street, highway, or alley. The term includes associated sidewalks, the roadbed, the right-of-way, and all culverts, drains, sluices, ditches, water storage areas, waterways, embankments, slopes, retaining walls, bridges, tunnels, and viaducts necessary for the maintenance of travel and all ferries used in connection therewith." Section 334.03(22), F.S.
[15] Chapter 57-777, s. 1, Laws of Fla., now codified at s. 125.42(5), F.S.
[16] Chapter 2009-85, s. 2, Laws of Fla., now codified at s. 125.42(5), F.S. Section 337.403(1)(e), F.S. requires the authority to pay for relocation costs if the utility, in an agreement entered into after July 1, 2009, conveyed, subordinated, or relinquished a property right to the authority for the purpose of accommodating the use or acquisition of a right-of-way.
[17] Chapter 2014-169, s. 1, Laws of Fla., now codified at s. 125.42, F.S.
[18] See definition of "road" in n. 14.
[19] "[A]uthority" means DOT and local governmental entities. s. 337.401(1), F.S.
[20] Chapter 57-1978, s. 1, Laws of Fla., now codified at s. 337.403, F.S.
[21] Chapter 1994-247, s. 28, Laws of Fla., now codified at s. 337.403, F.S.
[22] Section 337.403, F.S.
[23] Section 337.403(1)(a)-(i), F.S.
[24] Chapter 1987-100, s. 12, Laws of Fla., now codified at s. 337.403(1)(a), F.S.
[25] Chapter 1987-100, s. 12, Laws of Fla., now codified at s. 337.403(1)(b), F.S.
[26] Chapter 1999-385, s. 25, Laws of Fla., now codified at s. 337.403(1)(c), F.S.
[27] Chapter 2009-85, s. 10, Laws of Fla., now codified at s. 337.403(1)(d), F.S.
[28] Chapter 2009-85, s. 10, Laws of Fla., now codified at s. 337.403(1)(e), F.S.

- If the utility is an electric facility being relocated underground to enhance vehicular, bicycle, and pedestrian safety, and if ownership of the electric facility to be placed underground has been transferred from a private to a public utility within the past five years, DOT bears the cost of the necessary utility work.[29]
- An authority may bear the cost of utility work when the utility is not able to establish a compensable property right in the property where the utility is located:
    - If the utility was physically located on the particular property before the authority acquired rights in the property,[30]
    - The information available to the authority does not establish the relative priorities of the authority's and the utility's interest in the property,[31] and
    - The utility demonstrates that it has a compensable property right in all adjacent properties along the alignment of the utility[32] or, pursuant to a 2014 amendment, after due diligence, the utility certifies that it does not have evidence to prove or disprove it has a compensable property right in the particular property where the utility is located.[33]
- If a municipally-owned or county-owned utility is located in a rural area of critical economic concern[34] and DOT determines that the utility is unable, and will not be able within the next 10 years, to pay for the cost of utility work necessitated by a DOT project on the State Highway System, DOT may pay, in whole or in part, the cost of such utility work performed by DOT or its contractor.
- If the relocation of utility facilities is needed for the construction of a commuter rail service project or an intercity passenger rail service project, and the cost of the project is reimbursable by the Federal Government, then the utility that owns or operates the facilities located by permit on a DOT owned rail corridor shall perform all necessary utility relocation work after notice from DOT, and DOT must pay the expense for the utility relocation work in the same proportion as Federal funds are expended on the rail project after deducting any increase in the value of a new facility and any salvage value derived from an old facility.[35]

Also, in 2014, the Legislature clarified the 2009 exception that requires an authority to bear the costs to relocate a utility facility that was initially installed to exclusively serve the authority or its tenants. Under this clarification, if the utility facility was installed in the right-of-way to serve a county or municipal facility on property adjacent to the right-of-way and the county or municipal facility is intended to be used for purposes other than transportation purposes, the county or municipality is obligated to pay only for the utility work done outside the right-of-way.[36]

Florida statutory law is silent as to cost responsibility for relocation of utility facilities located on or along public roads or rights-of-way in circumstances other than those identified above. The U.S. Supreme Court, in reaffirming the common-law principle related to cost responsibility for utility relocation, has noted that "[i]t is a well-established principle of statutory construction that '[t]he common law ... ought not to be deemed repealed, unless the language of a statute be clear and explicit for this purpose.'"[37] Thus, in circumstances not explicitly addressed in Florida statutory law, the courts may apply the

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[29] Chapter 2009-85, s.10, Laws of Fla., now codified at s. 337.403(1)(f), F.S.
[30] Chapter 2012-174, s. 35, Laws of Fla., now codified at s. 337.403(1)(g)1., F.S.
[31] Chapter 2012-174, s. 35, Laws of Fla., now codified at s. 337.403(1)(g)3., F.S.
[32] Chapter 2012-174, s. 35, Laws of Fla., now codified at s. 337.403(1)(g)2., F.S.
[33] Chapter 2014-169, s. 5, Laws of Fla., now codified at s. 337.403(1)(g)2., F.S.
[34] Section 288.0656(2)(d) defines "rural area of critical economic concern" as "a rural community, or a region composed of rural communities, designated by the Governor, that has been adversely affected by an extraordinary economic event, severe or chronic distress, or a natural disaster or that presents a unique economic development opportunity of regional impact."
[35] Chapter 2014-169, s. 5, Laws of Fla., now codified at s. 337.403(1)(i), F.S. The exception expressly provides that in no event is the state required to use state dollars for such utility relocation work and that it does not apply to any phase of the Central Florida Rail Corridor project known as SunRail. Section 337.403(1)(i), F.S.
[36] ch. 2014-169, s. 5, Laws of Fla., now codified at s. 337.403(1)(d), F.S.
[37] *Norfolk Redevelopment & Hous. Auth.*, 464 U.S. at, 35 (1983), quoting *Fairfax's Devisee v. Hunter's Lessee,* 11 U.S. (7 Cranch) 603, 623, 3 L. Ed. 453 (1812).

common law principle requiring a utility to pay for relocation of its facilities as required by a governmental authority, absent an agreement otherwise or the presence of a private utility easement.

Specific Grant of Authority to Counties to Issue Licenses to Utilities

Section 125.42, F.S., gives counties the specific authority to grant a license to any person or private corporation to construct, maintain, repair, operate, and remove, within the unincorporated areas of a county, water, sewage, gas, power, telephone, other utility, and television transmission lines located under, on, over, across and *along* any county roads or highways.[38] The "under, on, over, across and along" county roads or highway language has been in the statute since 1947.[39]

In *Lee County Electric Cooperative, Inc. v. City of Cape Coral*, the court interpreted the term "along," as used in s. 337.403, F.S., in determining who would bear the burden of the cost of moving a utility line.[40] The interpretation of "along" informs its similar use in ss. 125.42 and 337.401, F.S.[41] The court determined that s. 337.403, F.S., codified common law and, applying the statute, the utility was responsible for bearing the costs of relocation.[42] The court did not find any "cases interpreting the 'along' the road portion of the statute," but determined the statutory language was clear, holding that "[t]he utility lines at issue . . . were located 'along' the road and they were 'interfering' with the City's 'expansion' of the road."[43]

Specific Grant of Authority to Regulate the Placement and Maintenance of Utility Facilities

Chapter 337, F.S., relates to public contracts and the acquisition, disposal, and use of property.[44] In relation to the placement and maintenance of utility facilities along, across, or on any public road or publicly owned rail corridor, current law authorizes the DOT and local governmental entities[45] to prescribe and enforce reasonable rules or regulations.[46] "Utility" in this context means any electric transmission, telephone, telegraph, or other communication services lines; pole lines; poles; railways; ditches; sewers; water, heat or gas mains; pipelines; fences; gasoline tanks and pumps; or other structures the statute refers to as a "utility."[47] Florida local governments have enacted ordinances regulating utilities located within city rights-of-way or easements.[48]

Effect of Proposed Changes

The bill revises several statutory provisions related to the placement and relocation of utility facilities. In general, the bill changes references to utility facilities located *along* public roads and publicly owned rail corridors to utility facilities located *within the right-of-way limits of* such roads and rail corridors. These changes specify the circumstances under which a utility must pay to remove or relocate its facilities (s. 337.403, F.S.), limit the authority of a county to grant licenses for utility transmission lines (s. 125.42, F.S.), and limit the authority of DOT and local governmental entities to prescribe and enforce rules or regulations relating to the placement or maintenance of utility facilities (s. 337.401, F.S.).

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[38] Section 125.42, F.S.
[39] Chapter 23850, ss. 1-3, Laws of Fla., now codified at s. 125.42, F.S.
[40] *Lee County Electric Coop., Inc. v. City of Cape Coral*, 159 So. 3d 126 (Fla. 2d DCA 2014), *cert. denied*, 151 So. 3d 1226 (Fla. 2014).
[41] "When a court interprets a statute, it is axiomatic that all parts of a statute must be read together in order to achieve a consistent whole [and], whenever possible, . . . give full effect to all statutory provisions and construe related statutory provisions in harmony with one another." *Almerico v. RLI Ins.*, 716 So. 2d 774, 779, n.7 (Fla. 1998) (citations & internal quotation marks omitted).
[42] *Lee County Electric Coop., Inc., supra n. 45,* at Part II of the opinion.
[43] *Id.* at 132.
[44] Sections 337.015 - 337.409, F.S.
[45] These are referred in ss. 337.401-337.404, F.S., as an "authority." s. 337.401(1)(a), F.S.
[46] Section 337.401, F.S.,
[47] Section 337.401(1)(a), F.S.
[48] *See* City of Cape Coral Code of Ordinances, Ch. 25; City of Jacksonville Code of Ordinances, Title XXI, Ch. 711; City of Orlando Code of Ordinances, Ch. 23.

Statutory Responsibility for Cost of Removal or Relocation of Utility Facilities

The bill limits a utility's responsibility to pay for the removal or relocation of its facilities that unreasonably interfere with the convenient, safe, or continuous use of, or the maintenance, improvement, extension, or expansion of, a public road or publicly owned rail corridor to only those facilities located *upon, under, over, or within the right-of-way limits of* the road or rail corridor, but not *along* the road or rail corridor. Thus, the bill draws a clearer distinction between utility facilities located within the right-of-way and those located outside the right-of-way but within a dedicated public utility easement.

This distinction is reinforced by the addition of an exception which requires DOT or the local government authority to pay for the relocation of facilities that unreasonably interfere with the convenient, safe, or continuous use of, or the maintenance, improvement, extension, or expansion of, a public road or publicly owned rail corridor where the facilities are located within a utility easement granted by recorded plat, regardless of whether such land was subsequently acquired by the authority by dedication, transfer of fee, or otherwise. To the extent an authority is required to bear the cost of relocating a utility, the bill provides that the authority shall pay the entire expense properly attributable to such work after deducting any increase in the value of a new facility and any salvage value derived from an old facility.

By eliminating the reference to facilities "along" a pubic road or publicly owned rail corridor and providing a specific exemption for the relocation of utilities located in a public utility easement, this provision removes the precedential effect of the *Lee County* case on facilities similarly located in public utility easements along a road or rail corridor but outside the right-of-way. Thus, the bill appears to shift cost responsibility in these instances to the governmental authority.

It is not clear how the provisions of the bill will impact utility relocation cost sharing as a practical matter. Utility representatives assert that local government authorities routinely pay to relocate utility facilities under current law. While local government representatives do not dispute this point, they assert these payments are made pursuant to negotiated agreements and for the purpose of efficiency in completing projects.

While the cost responsibility for many projects apparently is negotiated on a case-by-case basis, it is difficult to identify a clear and consistent prior practice upon which to determine the full, practical impact of this provision in the bill. However, to the extent these circumstances were previously resolved by negotiation between utility providers and local government entities, this bill could impact such negotiations. Responses to a survey by the Florida League of Cities suggest relocations from public utility easements are an uncommon occurrence, consistent with the position of utility representatives. Several municipalities reported one or fewer relocations from public utility easements in the recent past.[49] Two municipalities estimated the percentage of total city projects involving public utility easements, which was less than 5 percent in both cases.[50] A few municipalities, however, stated that relocations from public utility easements represented more than 20 percent of their projects.[51]

Specific Grant of Authority to Counties to Issue Licenses to Utilities

The bill provides that the authority of a county to grant a license to construct, maintain, repair, operate, or remove, within the unincorporated areas of the county, lines for the transmission of water, sewage,

[49] Utility Relocation Information Request Survey, Florida League of Cities (conducted electronically July 14, 2015 to Sept. 14, 2015). *E.g.* City of Archer (none in last 5 years), City of Lake Wales (none in last 12 years), City of North Miami Beach (1 in last 16 years), City of Palm Bay (1 in last 8 years).

[50] *Id.* City of Clearwater ("5% of Clearwater's projects involve public utility easements"); City of Fort Walton Beach ("only 2% [of city projects] lie within a utility easement.")

[51] *Id.* City of South Daytona ("20% of our relocation projects [are] within a public easement"); City of Deerfield Beach ("2 [of 4] utility relocation projects [last year] … were located within a public utility easement[.]").

gas, power, telephone, other utility, television lines, and other communications services[52] is limited to those lines located *under, on, over, across, or within the right-of-way limits* of any county roads or highways.[53] Accordingly, this change removes a county's authority to grant licenses for such lines running *along* a road or highway, but not within the actual right of way, which may include a public utility easement.

Specific Grant of Authority to Regulate the Placement and Maintenance of Utility Facilities

The bill narrows the authority of DOT and local governmental entities to prescribe and enforce reasonable rules or regulations in relation to the placing and maintaining of electric transmission, telephone, telegraph, or other communication services lines; pole lines; poles; railways; ditches; sewers; water, heat or gas mains; pipelines; fences; gasoline tanks and pumps; or other structures referred to as a utility, to the placement or maintenance of such utilities *across, on, or within the right-of-way limits* of any public road or publicly owned rail corridors.[54] By changing the language to "right-of-way," the bill removes the authority of DOT and local governments to prescribe and enforce reasonable rules and regulations regarding the placement and maintenance of the foregoing utilities *along* a public road or rail corridor, which may include a public utility easement. The bill also changes the expression "other structures referred to as a utility" to include structures referred to in ss. 337.402-337.404, F.S.[55]

Finding of Important State Interest

The bill provides the following legislative finding:

> The Legislature finds that a proper and legitimate state purpose is served by clarifying a utility's responsibility for relocating its facilities within a utility easement granted by recorded plat. Therefore, the Legislature determines and declares that this act fulfills an important state interest.

B. SECTION DIRECTORY:

Section 1: Amends s. 125.42, F.S., relating to water, sewage, gas, power, telephone, other utility and television line licenses.

Section 2: Amends s. 337.401, F.S., relating to rules or regulations concerning specified structures within public roads or rail corridors.

Section 3: Amends s. 337.403, F.S., relating to alleviating interference a utility causes to a public road or publicly owned rail corridor.

Section 4: Provides a legislative finding that the act fulfills an important state interest.

Section 5: Provides an effective date upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[52] The bill adds "other communications services" to the list of utilities in current law.
[53] Section 125.42(1), F.S.
[54] Current law references placement and maintenance "along, across, or on" any road or publicly owned rail corridors, rather than the "right-of-way of" any road or publicly owned rail corridors. Section 337.401(1)(a), F.S.
[55] Current law includes only those other structures referred to in s. 337.401, F.S., as a "utility," which includes "any electric transmission, telephone, telegraph, or other communications services lines; pole lines; poles; railways; ditches; sewers; water, heat, or gas mains; pipelines; fences; gasoline tanks and pumps." Section 337.401(1)(a), F.S.

2. Expenditures:

In its analysis, DOT indicates the bill will have an indeterminate negative impact on state government expenditures to the extent the costs associated with moving utilities are no longer covered by the utility company.[56] The analysis also notes that the bill could result in adjustments to planned projects in the DOT Work Program, to the extent funds are expended on utility relocations.[57]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Indeterminate. Several local government entities have provided projections of increased costs that would result from the bill. These projections include:

- City of Cape Coral, three road projects, $4,131,492;[58]
- City of St. Petersburg Water Resources Department, sewer infrastructure, $106,556 per year;[59]
- City of Port St. Lucie, completion of Crosstown Parkway Extension Project, between $200,000 and $600,000;[60]
- City of North Port[61] City of South Daytona,[62] and the City of Edgewater[63] stated the bill would increase their expenditures, but did not provide a projected amount.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. By requiring DOT or local government entities to bear the cost of relocation for facilities located in public utility easements, the bill would appear to reduce costs for utilities. Representatives of the utility industry assert the bill conforms the statute to established practice prior to the *Lee County* decision, thus protecting them from costs previously borne by local governments. Local government representatives assert that costs previously were negotiated on a case-by-case basis. Staff has requested and reviewed information from both utility and local government representatives, but, based on these limited circumstances, can only identify a clear and consistent prior practice of the parties generally relying on negotiated agreements to resolve the payment for relocation of utility facilities from public utility easements.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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[56] Florida Department of Transportation, Agency Analysis of 2016 House Bill 461 (dated November 3, 2015).
[57] *Id.*
[58] Florida League of Cities, *supra* note 49, City of Cape Coral response. It is not clear from response if these costs refer to a past or future project.
[59] Florida League of Cities, *supra* note 49, City of St. Petersburg response.
[60] Florida League of Cities, *supra* note 49, City of Port St. Lucie response.
[61] Florida League of Cities, *supra* note 49, City of North Port response.
[62] City of South Daytona Resolution No. 15-18.
[63] City of Edgewater Resolution No. 2015-R-34.

The municipality/county mandates provision of Art. VII, s. 18, of the Florida Constitution may apply since state and local governments would bear the cost of utility relocation from utility easements. However, an exception may apply since the bill applies to both state and local governments.[64]

If the bill does qualify as a mandate and no exemption is applicable, the law must fulfill an important state interest and final passage must be approved by two-thirds of the membership of each house of the Legislature. Section 4 of the bill provides a legislative finding that the bill fulfills an important state interest.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

To the extent DOT has any rules affected by this legislation, the agency may need to amend those rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[64] Art. VII, s. 18(a), Fla. Const.

1 A bill to be entitled
2 An act relating to the location of utilities; amending
3 s. 125.42, F.S.; revising the circumstances under
4 which a board of county commissioners is authorized to
5 grant to a person or private corporation a license for
6 specified projects related to lines for the
7 transmission of certain public utilities and
8 communication services; conforming a cross-reference;
9 amending s. 337.401, F.S.; authorizing the Department
10 of Transportation and certain local governmental
11 entities to prescribe and enforce rules or regulations
12 regarding the placement and maintenance of specified
13 structures and lines within the right-of-way limits of
14 roads or publicly owned rail corridors under their
15 respective jurisdictions; conforming cross-references;
16 amending s. 337.403, F.S.; specifying that the owner
17 of a utility located within certain right-of-way
18 limits must initiate and bear the cost necessary to
19 alleviate any interference to the use of certain
20 public roads or rail corridors under certain
21 circumstances; conforming a cross-reference; requiring
22 the authority to bear the cost of the utility work
23 necessary to eliminate an unreasonable interference if
24 the utility is lawfully located within a certain
25 utility easement, subject to certain deductions;
26 providing findings of an important state interest;

27 providing an effective date.
28
29 Be It Enacted by the Legislature of the State of Florida:
30
31 Section 1. Section 125.42, Florida Statutes, is amended to
32 read:
33 125.42 Water, sewage, gas, power, telephone, other
34 utility, and television lines within the right-of-way limits of
35 ~~along~~ county roads and highways.—
36 (1) The board of county commissioners, with respect to
37 property located without the corporate limits of any
38 municipality, is authorized to grant a license to any person or
39 private corporation to construct, maintain, repair, operate, and
40 remove lines for the transmission of water, sewage, gas, power,
41 telephone, other public utilities, ~~and~~ television, or other
42 communications services as defined in s. 202.11(1) under, on,
43 over, across, or within the right-of-way limits of ~~and along~~ any
44 county highway or any public road or highway acquired by the
45 county or public by purchase, gift, devise, dedication, or
46 prescription. However, the board of county commissioners shall
47 include in any instrument granting such license adequate
48 provisions:
49 (a) To prevent the creation of any obstructions or
50 conditions which are or may become dangerous to the traveling
51 public;
52 (b) To require the licensee to repair any damage or injury

53 to the road or highway by reason of the exercise of the
54 privileges granted in any instrument creating such license and
55 to repair the road or highway promptly, restoring it to a
56 condition at least equal to that which existed immediately prior
57 to the infliction of such damage or injury;
58 (c) Whereby the licensee shall hold the board of county
59 commissioners and members thereof harmless from the payment of
60 any compensation or damages resulting from the exercise of the
61 privileges granted in any instrument creating the license; and
62 (d) As may be reasonably necessary, for the protection of
63 the county and the public.
64 (2) A license may be granted in perpetuity or for a term
65 of years, subject, however, to termination by the licensor, in
66 the event the road or highway is closed, abandoned, vacated,
67 discontinued, or reconstructed.
68 (3) The board of county commissioners is authorized to
69 grant exclusive or nonexclusive licenses for the purposes stated
70 herein for television.
71 (4) This law is intended to provide an additional method
72 for the granting of licenses and shall not be construed to
73 repeal any law now in effect relating to the same subject.
74 (5) In the event of widening, repair, or reconstruction of
75 any such road, the licensee shall move or remove such water,
76 sewage, gas, power, telephone, and other utility lines and
77 television lines at no cost to the county should they be found
78 by the county to be unreasonably interfering, except as provided

79 in s. 337.403(1)(d)-(j) ~~s. 337.403(1)(d)-(i)~~.
80 Section 2. Paragraph (a) of subsection (1) of section
81 337.401, Florida Statutes, is amended to read:
82 337.401 Use of right-of-way for utilities subject to
83 regulation; permit; fees.—
84 (1)(a) The department and local governmental entities,
85 referred to in this section and in ss. 337.402, 337.403, and
86 337.404 ~~ss. 337.401-337.404~~ as the "authority," that have
87 jurisdiction and control of public roads or publicly owned rail
88 corridors are authorized to prescribe and enforce reasonable
89 rules or regulations with reference to the placing and
90 maintaining ~~along,~~ across, ~~or~~ on, or within the right-of-way
91 limits of any road or publicly owned rail corridors under their
92 respective jurisdictions any electric transmission, telephone,
93 telegraph, or other communications services lines; pole lines;
94 poles; railways; ditches; sewers; water, heat, or gas mains;
95 pipelines; fences; gasoline tanks and pumps; or other structures
96 referred to in this section and in ss. 337.402, 337.403, and
97 337.404 as the "utility." The department may enter into a
98 permit-delegation agreement with a governmental entity if
99 issuance of a permit is based on requirements that the
100 department finds will ensure the safety and integrity of
101 facilities of the Department of Transportation; however, the
102 permit-delegation agreement does not apply to facilities of
103 electric utilities as defined in s. 366.02(2).
104 Section 3. Subsection (1) of section 337.403, Florida

105 Statutes, is amended to read:
106 337.403 Interference caused by utility; expenses.—
107 (1) If a utility that is placed upon, under, over, or
108 within the right-of-way limits of ~~along~~ any public road or
109 publicly owned rail corridor is found by the authority to be
110 unreasonably interfering in any way with the convenient, safe,
111 or continuous use, or the maintenance, improvement, extension,
112 or expansion, of such public road or publicly owned rail
113 corridor, the utility owner shall, upon 30 days' written notice
114 to the utility or its agent by the authority, initiate the work
115 necessary to alleviate the interference at its own expense
116 except as provided in paragraphs (a)-(j) ~~(a)-(i)~~. The work must
117 be completed within such reasonable time as stated in the notice
118 or such time as agreed to by the authority and the utility
119 owner.
120 (a) If the relocation of utility facilities, as referred
121 to in s. 111 of the Federal-Aid Highway Act of 1956, Pub. L. No.
122 84-627, is necessitated by the construction of a project on the
123 federal-aid interstate system, including extensions thereof
124 within urban areas, and the cost of the project is eligible and
125 approved for reimbursement by the Federal Government to the
126 extent of 90 percent or more under the Federal Aid Highway Act,
127 or any amendment thereof, then in that event the utility owning
128 or operating such facilities shall perform any necessary work
129 upon notice from the department, and the state shall pay the
130 entire expense properly attributable to such work after

131 deducting therefrom any increase in the value of a new facility
132 and any salvage value derived from an old facility.
133 (b) When a joint agreement between the department and the
134 utility is executed for utility work to be accomplished as part
135 of a contract for construction of a transportation facility, the
136 department may participate in those utility work costs that
137 exceed the department's official estimate of the cost of the
138 work by more than 10 percent. The amount of such participation
139 is limited to the difference between the official estimate of
140 all the work in the joint agreement plus 10 percent and the
141 amount awarded for this work in the construction contract for
142 such work. The department may not participate in any utility
143 work costs that occur as a result of changes or additions during
144 the course of the contract.
145 (c) When an agreement between the department and utility
146 is executed for utility work to be accomplished in advance of a
147 contract for construction of a transportation facility, the
148 department may participate in the cost of clearing and grubbing
149 necessary to perform such work.
150 (d) If the utility facility was initially installed to
151 exclusively serve the authority or its tenants, or both, the
152 authority shall bear the costs of the utility work. However, the
153 authority is not responsible for the cost of utility work
154 related to any subsequent additions to that facility for the
155 purpose of serving others. For a county or municipality, if such
156 utility facility was installed in the right-of-way as a means to

157 serve a county or municipal facility on a parcel of property
158 adjacent to the right-of-way and if the intended use of the
159 county or municipal facility is for a use other than
160 transportation purposes, the obligation of the county or
161 municipality to bear the costs of the utility work shall extend
162 only to utility work on the parcel of property on which the
163 facility of the county or municipality originally served by the
164 utility facility is located.
165 (e) If, under an agreement between a utility and the
166 authority entered into after July 1, 2009, the utility conveys,
167 subordinates, or relinquishes a compensable property right to
168 the authority for the purpose of accommodating the acquisition
169 or use of the right-of-way by the authority, without the
170 agreement expressly addressing future responsibility for the
171 cost of necessary utility work, the authority shall bear the
172 cost of removal or relocation. This paragraph does not impair or
173 restrict, and may not be used to interpret, the terms of any
174 such agreement entered into before July 1, 2009.
175 (f) If the utility is an electric facility being relocated
176 underground in order to enhance vehicular, bicycle, and
177 pedestrian safety and in which ownership of the electric
178 facility to be placed underground has been transferred from a
179 private to a public utility within the past 5 years, the
180 department shall incur all costs of the necessary utility work.
181 (g) An authority may bear the costs of utility work
182 required to eliminate an unreasonable interference when the

183 utility is not able to establish that it has a compensable
184 property right in the particular property where the utility is
185 located if:
186 1. The utility was physically located on the particular
187 property before the authority acquired rights in the property;
188 2. The utility demonstrates that it has a compensable
189 property right in adjacent properties along the alignment of the
190 utility or, after due diligence, certifies that the utility does
191 not have evidence to prove or disprove that it has a compensable
192 property right in the particular property where the utility is
193 located; and
194 3. The information available to the authority does not
195 establish the relative priorities of the authority's and the
196 utility's interests in the particular property.
197 (h) If a municipally owned utility or county-owned utility
198 is located in a rural area of opportunity, as defined in s.
199 288.0656(2), and the department determines that the utility is
200 unable, and will not be able within the next 10 years, to pay
201 for the cost of utility work necessitated by a department
202 project on the State Highway System, the department may pay, in
203 whole or in part, the cost of such utility work performed by the
204 department or its contractor.
205 (i) If the relocation of utility facilities is
206 necessitated by the construction of a commuter rail service
207 project or an intercity passenger rail service project and the
208 cost of the project is eligible and approved for reimbursement

209 by the Federal Government, then in that event the utility owning
210 or operating such facilities located by permit on a department-
211 owned rail corridor shall perform any necessary utility
212 relocation work upon notice from the department, and the
213 department shall pay the expense properly attributable to such
214 utility relocation work in the same proportion as federal funds
215 are expended on the commuter rail service project or an
216 intercity passenger rail service project after deducting
217 therefrom any increase in the value of a new facility and any
218 salvage value derived from an old facility. In no event shall
219 the state be required to use state dollars for such utility
220 relocation work. This paragraph does not apply to any phase of
221 the Central Florida Commuter Rail project, known as SunRail.
222 (j) If a utility is lawfully located within an existing
223 and valid utility easement granted by recorded plat, regardless
224 of whether such land was subsequently acquired by the authority
225 by dedication, transfer of fee, or otherwise, the authority must
226 bear the cost of the utility work required to eliminate an
227 unreasonable interference. The authority shall pay the entire
228 expense properly attributable to such work after deducting any
229 increase in the value of a new facility and any salvage value
230 derived from an old facility.
231 Section 4. The Legislature finds that a proper and
232 legitimate state purpose is served by clarifying a utility's
233 responsibility for relocating its facilities within a utility
234 easement granted by recorded plat. Therefore, the Legislature

235 determines and declares that this act fulfills an important
236 state interest.
237 Section 5. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 761 Fraudulent Activities Associated with Payment Systems
SPONSOR(S): Criminal Justice Subcommittee; Young and others
TIED BILLS: None **IDEN./SIM. BILLS:** CS/SB 912

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Criminal Justice Subcommittee	11 Y, 0 N, As CS	White	White
2) Appropriations Committee		McAuliffe	Leznoff
3) Judiciary Committee			

SUMMARY ANALYSIS

The Department of Agriculture and Consumer Services (DACS) is responsible for inspecting measuring devices, i.e., fuel pumps, which are used in this state to sell fuel at wholesale and retail. In executing this responsibility, DACS also inspects the pumps for devices, commonly referred to as "skimmers," which steal payment card information from customers paying for their gas at the pump.

During recent investigations, DACS has found that skimmed payment card information is being used as part of elaborate fraud schemes to purchase hundreds of gallons of gas that is pumped into unapproved, hidden gas tanks in vans, SUVs, and trucks. Such gas is then usually resold by the criminals to independent truck drivers at a fraction of its usual cost.

To establish greater protection for consumer payment card information and enhance penalties for crimes involved in the fraud schemes, the bill:

- Requires owners and managers of retail fuel pumps in this state to affix or install one or more security measures on each fuel pump which restrict the unauthorized access of customer payment card information.
- Increases the penalty for the offense of unlawfully conveying and fraudulently obtaining fuel from an unranked third degree felony to a second degree felony ranked as a Level 5 offense on the Offense Severity Ranking Chart (OSRC).
- Reduces the number of counterfeit credit cards or related specified documents required to constitute second degree felony trafficking from 10 to five and ranks this felony as a Level 5 offense on the OSRC.
- Creates a second degree felony ranked as a Level 5 offense on the OSRC for the offense of possessing five or more counterfeit credit cards or related specified documents.

On January 5, 2016, the Criminal Justice Impact Conference determined that this bill will have an insignificant impact on state prison beds (i.e., will increase the number of prison beds needed by less than 10). The bill may also increase the need for local jail beds and have a minimal fiscal impact on the owners and managers of retail petroleum fuel pumps. Please see "Fiscal Analysis & Economic Impact Statement."

The bill takes effect on October 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Skimming

As discussed below, the Department of Agriculture and Consumer Services (DACS) is responsible for inspecting measuring devices, i.e., fuel pumps, which are used in this state to sell fuel at wholesale and retail.[1] In executing this responsibility, DACS also inspects the fuel pumps for devices, commonly referred to as "skimmers," which steal payment card information from customers paying for their gas at the pump.[2]

In addition to being used for typical fraudulent purchases, skimmed payment card information has also been used, according to DACS, as part of elaborate schemes to purchase hundreds of gallons of gas that is pumped into unapproved, hidden gas tanks in vans, SUVs, and trucks. Such gas is then usually resold by the criminals to independent truck drivers at a fraction of its usual cost.[3]

The DACS has been working in cooperation with local, state, and federal law enforcement officials to investigate the criminals operating the above-described schemes.[4] Since March 2015, DACS has found 166 skimmers statewide and estimates that between 100 and 5,000 consumers are victimized by each skimmer with an average of $1,000 stolen from each victim.[5] Additionally, since 2008, DACS has arrested 47 persons for the theft of fuel using skimmed credit card information.[6]

Regulation of Petroleum Fuel Measuring Devices

Under s. 525.07(1), F.S., DACS is required to inspect all measuring devices used in selling or distributing petroleum fuel[7] at wholesale and retail. The section further authorizes DACS to establish by rule the tolerances, in excess or deficiency, to be allowed for such measuring devices and requires each person who owns or operates a measuring device to ensure accurate measurement and to place an appropriate security seal on each device so that the metering adjustment cannot be changed without breaking the seal.[8]

If DACS determines that a measuring device is operating outside the tolerances established in rule, DACS is authorized to:

- Give written notice to the operator or owner of the measuring device which provides a reasonable time to repair the measuring device; or

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[1] s. 525.07, F.S.

[2] *See* Florida Department of Agriculture and Consumer Services, *Protecting Consumers at the Pump* (on file with the House Criminal Justice Subcommittee).

[3] *Id.*

[4] *Id.*

[5] Florida Department of Agriculture and Consumer Services, *Commissioner Putnam Highlights "Protection at the Pump" Legislation, Announces Six Skimmers Found in Tampa Bay Area,* http://www.freshfromflorida.com/News-Events/Press-Releases/2015-Press-Releases/Commissioner-Putnam-Highlights-Protection-at-the-Pump-Legislation-Announces-Six-Skimmers-Found-in-Tampa-Bay-Area (last visited Jan. 16, 2016).

[6] *See* Florida Department of Agriculture and Consumer Services, *Protecting Consumers at the Pump* (on file with the House Criminal Justice Subcommittee).

[7] The term "petroleum fuel" is defined to mean "all gasoline, kerosene (except when used as aviation turbine fuel), diesel fuel, benzine, other like products of petroleum under whatever name designated, or an alternative fuel used for illuminating, heating, cooking, or power purposes, sold, offered, or exposed for sale in this state." s. 525.01(1)(b), F.S. "Alternative fuel" is defined to mean "1. Methanol, denatured ethanol, or other alcohols; 2. Mixtures of gasoline or other fuels with methanol, denatured ethanol, or other alcohols; 3. Hydrogen; 4. Coal-derived liquid fuels; and 5. Fuels, other than alcohol, derived from biological materials." s. 525.01(1)(c), F.S.

[8] s. 525.07(2) and (3), F.S.

- Condemn or prohibit the further use of the measuring device by using an appropriate security seal to obstruct the mechanism so that it cannot be operated without breaking the seal.[9]

The section further specifies that it is unlawful for any person to:

- Operate any measuring device that has been condemned or prohibited from further use by the department without the written consent of the department.
- Install or operate a petroleum fuel measuring device in this state which gives short measure.
- Break, cut, or remove any seal applied by the department to a petroleum fuel measuring device or container, except under specified circumstances involving repair of the device.[10]

A violation of the section's provisions:

- May result in the imposition of administrative fines by DACS and suspension or revocation of the registration issued by DACS to the owner or operator of a measuring device.
- Constitutes a first degree misdemeanor[11] if knowingly committed.[12]

Effect of Bill

The bill adds a new subsection (10) to s. 525.07, F.S., to require each owner or manager of a retail petroleum fuel measuring device to affix or install at least one of the following security measures onto the fuel measuring device to restrict the unauthorized access of customer payment card[13] information:

- Pressure-sensitive security tape that is placed over the panel opening that leads to the scanning device for the fuel measuring device in a manner that restricts the unauthorized opening of the panel.
- A device or system that renders the fuel measuring device or the scanning device[14] in the fuel measuring device inoperable if there is an unauthorized opening of the panel.
- A device or system that encrypts the customer payment card information in the scanning device.
- Another security measure approved by the DACS.

If DACS determines that an owner or a manager does not have a security measure or has an altered or damaged security measure, the owner or manager shall have five calendar days after written notice from DACS to achieve compliance. After the fifth day of noncompliance, DACS may prohibit further use of the retail petroleum fuel measuring device until compliance is achieved. If a repeat violation occurs, DACS may take the measuring device out of service.

The bill requires DACS to enforce the aforementioned requirements and authorizes DACS to adopt rules to implement the new subsection.

Unlawful Conveyance of Fuel/Fraudulent Obtainment of Fuel

Section 316.80(1), F.S., states that it is unlawful for any person to maintain or possess any conveyance or vehicle that is equipped with fuel tanks, bladders, drums, or other containers that do not conform to federal regulations[15] or have not been approved by the United States Department of Transportation for the purpose of hauling, transporting, or conveying fuel over any public highway. A person who violates

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[9] s. 525.07(4), F.S.

[10] s. 525.07(5)-(7), F.S.

[11] A first degree misdemeanor is punishable by up to one year in county jail and a $1,000 fine. ss. 775.082 and 775.083, F.S.

[12] s. 525.16, F.S.

[13] The bill defines "payment card" as meaning "a credit card, charge card, debit card, or any other card that is issued to an authorized card user and that allows the user to obtain, purchase, or receive goods, services, money, or anything else of value from a merchant." ss. 525.07(10)(b) and 817.625(1)(c), F.S.

[14] The bill defines "scanning device" as meaning "a scanner, reader, or any other electronic device that is used to access, read, scan, obtain, memorize, or store, temporarily or permanently, information encoded on the magnetic strip or stripe of a payment card." ss. 525.07(10)(b) and 817.625(1)(a), F.S.

[15] These regulations are set forth in Title 49 of the Code of Federal Regulations, entitled "Transportation."

this prohibition commits a third degree felony[16] and is subject to the revocation of driver license privileges as provided in s. 322.26, F.S.

Additionally, s. 316.80(2), F.S., specifies that it is a third degree felony for any person to violate the above-described offense and to have or attempted to have fraudulently obtained fuel by:

- Presenting a credit card or a credit card account number in violation of Part II of ch. 817, F.S., entitled the "State Credit Card Crime Act";
- Using unauthorized access to any computer network in violation of s. 815.06;[17] or
- Using a fraudulently scanned or lost or stolen payment access device, whether credit card or contactless device.[18]

The third degree felony offenses established in s. 316.80(1) and (2), F.S., are not currently ranked in the Offense Severity Ranking Chart (OSRC),[19] and, as such, default to Level 1 offenses for purposes of a defendant's sentencing scoresheet.[20]

Effect of Bill
The bill amends s. 316.80(2), F.S., to make it a second degree felony, rather than third degree felony as in current law, to unlawfully convey and fraudulently obtain fuel. The bill also amends s. 921.0022(3)(e), F.S., to rank this second degree felony as a Level 5 on the OSRC, which is one level higher than the Level 4 default ranking that applies to an unranked second degree felony offense.

State Credit Card Crime Act
Part II of ch. 817, F.S., entitled the "State Credit Card Crime Act," sets forth various criminal offenses prohibiting the theft, fraudulent use, and trafficking of credit cards[21] and counterfeit credit cards.[22] Relevant to this bill is s. 817.611, F.S., which specifies that it is a second degree felony[23] for any person to traffic in or attempt to traffic in 10 or more counterfeit credit cards, invoices, vouchers, sales drafts, or other representations or manifestations of counterfeit credit cards, or credit card account numbers of another in any six-month period. The term "traffic" means "to sell, transfer, distribute, dispense, or otherwise dispose of a property or to buy, receive, possess, obtain control of, or use property with the intent to sell, transfer, distribute, dispense, or otherwise dispose of such property."[24]

This second degree felony offense is not currently ranked on the OSRC, and, as such, defaults to a Level 4 offense for purposes of a defendant's sentencing scoresheet.[25]

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[16] A third degree felony is punishable by up to five years imprisonment and a $5,000 fine. ss. 775.082 and 775.083, F.S.
[17] Section 815.06, F.S., specifies multiple offenses relating to unauthorized access of computer networks which range from a first degree misdemeanor to a first degree felony, e.g., it is a third degree felony to access a network with the knowledge that such access is unauthorized.
[18] Section 316.80(2), F.S.
[19] The Offense Severity Ranking Chart ranges from a Level 1 (least severe) to a Level 10 (most severe). A higher level results in a greater number of sentencing points being calculated on a defendant's sentencing scoresheet. The scoresheet determines the lowest permissible sentence that a defendant may receive, unless the trial court is statutorily-authorized to depart from such sentence. ss. 921.0022 and 921.0024, F.S.
[20] If an offense is not listed in the ranking chart, it defaults to a: (a) Level 1 for a third degree felony; (b) Level 4 for a second degree felony; (c) Level 7 for a first degree felony; (d) Level 9 for a first degree felony punishable by life; and (e) Level 10 for a life felony s. 921.0023, F.S.
[21] The term "credit card" is defined to mean, "any instrument or device, whether known as a credit card, credit plate, bank service card, banking card, check guarantee card, electronic benefits transfer (EBT) card, or debit card or by any other name, issued with or without fee by an issuer for the use of the cardholder in obtaining money, goods, services, or anything else of value on credit or for use in an automated banking device to obtain any of the services offered through the device." s. 817.58(4), F.S.
[22] The term "counterfeit credit card" is defined as, "any credit card which is fictitious, altered, or forged; any facsimile or false representation, depiction, or component of a credit card; or any credit card which is stolen, obtained as part of a scheme to defraud, or otherwise unlawfully obtained, and which may or may not be embossed with account information or a company logo." s. 817.58(3), F.S.
[23] A second degree felony is punishable by up to 15 years imprisonment and a $10,000 fine. ss. 775.082 and 775.083, F.S.
[24] s. 817.58(10), F.S.
[25] s. 921.0023, F.S.

Effect of Bill
The bill amends s. 817.611, F.S., to reduce the number of counterfeit credit cards or related specified documents required to constitute a trafficking offense from 10 to five. It also amends the section to make the possession of, in addition to the trafficking of, such counterfeit credit cards or related specified documents a second degree felony. Finally, the bill amends s. 921.0022(3)(e), F.S., to rank the second degree felony violation of s. 817.611, F.S., as a Level 5 on the OSRC.

B. SECTION DIRECTORY:

Section 1. Amending s. 316.80, F.S., relating to unlawful conveyance of fuel and obtaining fuel fraudulently.

Section 2. Amending s. 525.07, F.S., relating to the powers and duties of DACS, inspections, and unlawful acts.

Section 3. Amending s. 817.611, F.S., relating to trafficking in counterfeit credit cards.

Section 4. Amending s. 921.0022, F.S., relating to the OSRC.

Section 5. Providing an effective date of October 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

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

2. Expenditures:

   The Criminal Justice Impact Conference met on January 5, 2016, and determined that this bill will have an insignificant prison bed impact on the Department of Corrections (i.e., the bill will increase the number of prison beds needed by less than 10) due to its: (a) increase in s. 316.80(2), F.S., of the penalties applicable to the offense of unlawfully conveying and fraudulently obtaining fuel from an unranked third degree felony to a second degree felony ranked at a Level 5; (b) reduction in s. 817.611, F.S., of the number of counterfeit credit cards or related specified documents necessary to constitute trafficking; (c) creation in s. 817.611, F.S., of the second degree felony for possession of counterfeit credit cards or related specified documents; and (d) ranking of the currently unranked second degree felonies in s. 817.611, F.S., as Level 5 offenses.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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

2. Expenditures:

   Due to the bill's addition of a requirement for an owner or manager of a retail petroleum fuel measuring device to install one or more security measures, the bill may increase the need for local jail beds because a knowing violation of this requirement constitutes a first degree misdemeanor under s. 525.16(2), F.S.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a fiscal impact on owners or managers of retail petroleum fuel measuring devices due to its requirement for the installation of one or more security measures on such device. As this requirement may be satisfied by the installation of pressure-sensitive security tape, the fiscal impact is anticipated to be minimal.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill appears to be exempt from the requirements of Article VII, Section 18 of the Florida Constitution because it is a criminal law.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill authorizes the DACS to adopt rules to implement s. 525.07(10), F.S., relating to the bill's new requirement for implementation of one or more security measures to protect customer payment card information for each retail petroleum measuring device in this state.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 19, 2016, the Criminal Justice Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment: (a) substitutes the phrase "owner or manager" for "owner or operator" throughout s. 525.07, F.S., to clarify that the section's requirements apply to managers of petroleum fuel measuring devices, i.e., fuel pumps, not mere operators of such pumps; (b) specifies additional means by which owners and managers may comply with the security measure requirement set forth in s. 525.07(10), F.S.; and (c) addresses altered or damaged security measures in s. 525.07(10)(b), F.S.

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

1 A bill to be entitled
2 An act relating to fraudulent activities associated
3 with payment systems; amending s. 316.80, F.S.;
4 revising the felony classification for unlawful
5 conveyance of fuel; amending s. 525.07, F.S; revising
6 terminology to specify requirements for managers,
7 rather than operators, of petroleum fuel measuring
8 devices with respect to accurate measurement;
9 requiring retail petroleum fuel measuring devices
10 fitted with scanning devices to have certain security
11 measures; providing requirements for such measures;
12 requiring the owner or operator of a device to have
13 certain security measures in place within a specified
14 timeframe upon notice from the Department of
15 Agriculture and Consumer Services; authorizing the
16 department, under certain circumstances, to prohibit
17 use of or to remove from service such devices that are
18 noncompliant; defining terms; providing applicability;
19 requiring the Department of Agriculture and Consumer
20 Services to enforce provisions; providing for
21 rulemaking; amending s. 817.611, F.S.; reducing the
22 number of counterfeit credit cards that a person can
23 be in possession of to qualify as unlawful; amending
24 s. 921.0022, F.S.; ranking unlawful conveyance or
25 fraudulent acquisition of fuel as a level 5 offense;
26 ranking trafficking in or possession of counterfeit

27 credit cards as a level 5 offense; providing an
28 effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Subsection (2) of section 316.80, Florida
33 Statutes, is amended to read:
34 316.80 Unlawful conveyance of fuel; obtaining fuel
35 fraudulently.—
36 (2) A ~~Any~~ person who violates subsection (1) commits a
37 felony of the second ~~third~~ degree, punishable as provided in s.
38 775.082, s. 775.083, or s. 775.084, if he or she has attempted
39 to or has fraudulently obtained motor or diesel fuel by:
40 (a) Presenting a credit card or a credit card account
41 number in violation of ss. 817.57-817.685;
42 (b) Using unauthorized access to any computer network in
43 violation of s. 815.06; or
44 (c) Using a fraudulently scanned or lost or stolen payment
45 access device, whether credit card or contactless device.
46 Section 2. Subsections (3) and (4) of section 525.07,
47 Florida Statutes, are amended, and subsection (10) is added to
48 that section, to read:
49 525.07 Powers and duties of department; inspections;
50 unlawful acts.—
51 (3) Each person who owns or manages ~~All persons who own or~~
52 ~~operate~~ a petroleum fuel measuring device is ~~shall be~~

53 responsible for ensuring accurate measure by the device within
54 the tolerances defined by the rule. An appropriate security seal
55 shall be placed on all measuring devices found to be giving
56 accurate measure within the tolerances defined by the department
57 in such a way that the metering adjustment cannot be changed
58 without breaking the seal.
59 (4) A ~~Any~~ measuring device that is found to be operating
60 outside the tolerances defined by the department is ~~shall be~~
61 deemed inaccurate, and the department, at its discretion, shall
62 either:
63 (a) Give, in writing, the ~~operator or~~ owner or manager of
64 the measuring device a reasonable time to repair the measuring
65 device; or
66 (b) Condemn or prohibit the further use of the measuring
67 device by using an appropriate security seal to obstruct the
68 mechanism so that it cannot be operated without breaking the
69 seal. The measuring device shall not be operated in this state
70 again without the written consent of the department.
71 (10)(a) Each person who owns or manages a retail petroleum
72 fuel measuring device shall have affixed to or installed onto
73 the measuring device a security measure to restrict the
74 unauthorized access of customer payment card information. The
75 security measure must include one or more of the following:
76 1. Placement of pressure-sensitive security tape over the
77 panel opening that leads to the scanning device for the retail
78 petroleum fuel measuring device in a manner that will restrict

79 the unauthorized opening of the panel.
80 2. A device or system that will render the retail
81 petroleum fuel measuring device or the scanning device in the
82 measuring device inoperable if there is an unauthorized opening
83 of the panel.
84 3. A device or system that encrypts the customer payment
85 card information in the scanning device.
86 4. Another security measure approved by the department.
87 (b) The owner or manager of a retail petroleum fuel
88 measuring device without a security measure or with an altered
89 or damaged security measure, upon written notice from the
90 department of such noncompliance, shall have 5 calendar days to
91 comply with this subsection. After the fifth day of
92 noncompliance, the department may prohibit further use of the
93 retail petroleum fuel measuring device until a security measure
94 is installed, replaced, or repaired. A repeat violation found on
95 the same retail petroleum fuel measuring device is cause for the
96 department to immediately take the measuring device out of
97 service.
98 (c) For purposes of this subsection, the terms "scanning
99 device" and "payment card" have the same meanings as provided in
100 s. 817.625.
101 (d) This subsection applies only to retail petroleum fuel
102 measuring devices that have a scanning device.
103 (e) The department shall enforce, and may adopt rules to
104 implement, this subsection.

105 Section 3. Section 817.611, Florida Statutes, is amended
106 to read:
107 817.611 Traffic in or possess counterfeit credit cards.—
108 Any person who traffics in, ~~or~~ attempts to traffic in, or
109 possesses 5 ~~10~~ or more counterfeit credit cards, invoices,
110 vouchers, sales drafts, or other representations or
111 manifestations of counterfeit credit cards, or credit card
112 account numbers of another in any 6-month period is guilty of a
113 felony of the second degree, punishable as provided in s.
114 775.082, s. 775.083, or s. 775.084.
115 Section 4. Paragraph (e) of subsection (3) of section
116 921.0022, Florida Statutes, is amended to read:
117 921.0022 Criminal Punishment Code; offense severity
118 ranking chart.—
119 (3) OFFENSE SEVERITY RANKING CHART
120 (e) LEVEL 5
121

Florida Statute	Felony Degree	Description
316.027(2)(a)	3rd	Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.

122

316.1935(4)(a)	2nd	Aggravated fleeing or eluding.
316.80(2)	2nd	Unlawful conveyance; obtaining fuel fraudulently.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
379.367(4)	3rd	Willful molestation of a commercial harvester's spiny lobster trap, line, or buoy.
379.3671	3rd	Willful molestation,

	(2)(c)3.		possession, or removal of a commercial harvester's trap contents or trap gear by another harvester.
132			
	381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
133			
	440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
134			
	440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
135			
	440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
136			
	624.401(4)(b)2.	2nd	Transacting insurance

			without a certificate or authority; premium collected $20,000 or more but less than $100,000.
137	626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
138	790.01(2)	3rd	Carrying a concealed firearm.
139	790.162	2nd	Threat to throw or discharge destructive device.
140	790.163(1)	2nd	False report of deadly explosive or weapon of mass destruction.
141	790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
142	790.23	2nd	Felons in possession of firearms, ammunition, or

			electronic weapons or devices.
143	796.05(1)	2nd	Live on earnings of a prostitute; 1st offense.
144	800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years of age.
145	800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years of age or older.
146	806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
147	812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
148	812.015(8)	3rd	Retail theft; property stolen is valued at $300

		or more and one or more specified acts.
149		
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
150		
812.131(2)(b)	3rd	Robbery by sudden snatching.
151		
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
152		
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
153		
817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
154		
817.2341(1), (2)(a) & (3)(a)	3rd	Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency

		of an insuring entity.
817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.
817.611	2nd	Traffic in or possess counterfeit credit cards.
817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device or reencoder.
825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.

161	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
162	827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
163	839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
164	843.01	3rd	Resist officer with violence to person; resist arrest with violence.
165	847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18

			years or older.
847.0137 (2) & (3)	3rd		Transmission of pornography by electronic device or equipment.
847.0138 (2) & (3)	3rd		Transmission of material harmful to minors to a minor by electronic device or equipment.
874.05(1)(b)		2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.
874.05(2)(a)		2nd	Encouraging or recruiting person under 13 years of age to join a criminal gang.
893.13(1)(a)1.		2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.13(1)(c)2.		2nd	Sell, manufacture, or

			deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
172	893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs) within 1,000 feet of university.
173	893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3.,

			(2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
174	893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)4. drugs) within 1,000 feet of public housing facility.
175	893.13(4)(b)	2nd	Deliver to minor cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).
176	893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or

manufacturing of controlled substance.

177

178 Section 5. This act shall take effect October 1, 2016.

CS/HB 769

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 769 Mental Health Treatment
SPONSOR(S): Children, Families & Seniors Subcommittee, Peters
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 862

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	8 Y, 0 N, As CS	McElroy	Brazzell
2) Appropriations Committee		Smith	Leznoff
3) Judiciary Committee			

SUMMARY ANALYSIS

HB 769 addresses issues related to administration of psychotropic medications, evaluations of individuals' competency and transportation to competency and commitment hearings for forensic clients. The bill makes changes to ch. 916, F.S., as follows:

- Requires an admitting physician in a state forensic or civil facility to continue the administration of psychotropic medication previously prescribed in jail when a forensic client lacks the capacity to make an informed decision and, in the physician's opinion, the abrupt cessation of medication could risk the health and safety of the client. This authority is limited to the time period required to obtain a court order for the medication;
- Requires that a court hold a hearing within 30 days after receiving notification from a treatment facility that a defendant who was previously adjudicated incompetent or was previously adjudicated not guilty by reason of insanity is now competent to proceed or no longer meets criteria for continued commitment;
- Requires the defendant to be transported to the committing court's jurisdiction for the hearing.
- Permits a court to dismiss charges for specified nonviolent offenses for an individual whom the court has determined to be incompetent to proceed and who remains incompetent for 3 years after the original determination.
- Changes the timeframe for mandatory dismissal of all charges for an individual whom the court has determined to be incompetent to proceed and who remains incompetent to 5 continuous, uninterrupted years since the court's original determination of incompetency.

The bill would have an insignificant fiscal impact to state expenditures.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Competency

The Due Process Clause of the 14th Amendment prohibits the states from trying and convicting defendants who are incompetent to stand trial.[1] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[2] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[3]

If a defendant is suspected of being incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[4] If the motion is well-founded the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[5] If the defendant is found to be competent, the criminal proceeding resumes.[6] If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.[7]

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed[8] and offenders who are adjudicated not guilty by reason of insanity may be involuntarily committed to state civil[9] and forensic[10] treatment facilities by the circuit court,[11] or in lieu of such commitment, may be released on conditional release[12] by the circuit court if the person is not serving a prison sentence.[13] Conditional release is release into the community accompanied by outpatient care and treatment. The

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[1] See Pate v. Robinson, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); Bishop v. U.S., 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); Jones v. State, 740 So.2d 520 (Fla. 1999).
[2] Id. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[3] Id. See also s. 916.12, 916.3012, and 985.19, F.S.
[4] Rule 3.210, Fla.R.Crim.P.
[5] Id.
[6] Rule 3.212, Fla.R.Crim.P.
[7] Id.
[8] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." s. 916.12(1), F.S.
[9] A "civil facility" is: a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.
[10] A "forensic facility" is a separate and secure facility established within DCF or APD to service forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents. Section 916.106(10), F.S.
[11] Sections 916.13, 916.15, and 916.302, F.S.
[12] Conditional release is release into the community accompanied by outpatient care and treatment. S. 916.17, F.S.
[13] Section 916.17(1), F.S.

committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[14]

Sections 916.13 and 916.15, F.S., set forth the criteria under which a court may involuntarily commit a defendant charged with a felony who has been adjudicated incompetent to proceed, or who has been found not guilty by reason of insanity. If a person is committed pursuant to either statute, the administrator at the commitment facility must submit a report to the court:

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.[15]

The statutes are silent as to a time frame in which the court must hold a hearing to determine continued competency or the continued need for involuntary commitment. The statutes are additionally silent as to transportation of the defendant to the committing court's jurisdiction for these hearings. The time frame for the hearings are set forth in Florida Rules of Criminal Procedure which require the court to hold a hearing within 30 days of receiving a report from a facility administrator that indicates that a person adjudicated incompetent to proceed or not guilty by reason of insanity no longer meets the criteria for commitment.[16] However, there is no express requirement within the Florida Rules of Criminal Procedure to transport the defendant to committing court's jurisdiction for these hearings.

Dismissal of Charges

Section 916.145, F.S., requires all charges against any defendant adjudicated incompetent to proceed due to mental illness be dropped if the defendant remains incompetent to proceed five years after the initial determination. However, court may extend the time period to dismiss the charges beyond 5 years if in its order specifies its reasons for believing that a defendant will become competent to proceed within the foreseeable future and specifies the time within which a defendant is expected to become competent to proceed.[17] Any charges dismissed under this section are dismissed without prejudice which allows the state to refile the charges should a defendant be declared competent to proceed in the future.[18]

Psychotropic Medication Treatment

Currently, forensic clients[19] must give express and informed consent to treatment.[20] If they refuse and the situation is deemed an emergency that puts the client's safety at risk, treatment may be given for 48 hours.[21] If the person still refuses to give consent, a court order must be sought for continuation of the treatment.[22] In non-emergency situations, treatment may not be given without the client's consent.[23] Instead, the facility administrator or designee must petition the court for an order authorizing necessary and essential treatment for the client, including administration of psychotropic medication.[24] There will be a delay between the time in which the petition is filed and the hearing for the petition. In this interim the client will not receive any psychotropic medication, even if he or she was receiving this medication

[14] Section 916.16(1), F.S.
[15] Section 916.13(2), F.S.; section 916.15(3), F.S.
[16] Rules 3.212(c)(6) and 3.218(b) Florida Rules of Criminal Procedure.
[17] S. 916.145, F.S.
[18] Id.
[19] Forensic clients are individuals who have been committed to DCF, pursuant to ch. 916, F.S., because they have been charged with committing a felony but been adjudicated incompetent, adjudicated not guilty by reason of insanity, or determined to be incompetent to proceed.
[20] Section 916.107(3)(a), F.S.
[21] S. 916.107(3)(a)1., F.S.
[22] Id.
[23] Section 916.107(3)(a)2., F.S.
[24] Id.

at the jail. This creates a delay in treatment which could potentially lead to a client's decompensation and prolong the client's length of stay at the facility.

Effect of Proposed Changes

Competency

The bill amends ss. 916.13 and 916.15, F.S., to require a competency hearing to be held within 30 days after the court has been notified that a defendant is competent to proceed, or no longer meets the criteria for continued commitment. The bill also requires that the defendant be transported to committing court's jurisdiction for these hearings. These requirements are consistent with Rule 3.212(c)(6), Florida Rules of Criminal Procedure, and should help make vacancies available at secure facilities for individuals awaiting admission. As statutorily mandated, forensic individuals committed to the care of DCF for involuntary hospitalization must be admitted within 15 days of commitment.

Dismissal of Charges

The bill amends s. 916.145, F.S., to require that all charges be dismissed if the defendant remains incompetent to proceed for 5 continuous, uninterrupted years after the initial determination. The bill also permits a court to dismiss charges for an individual whom the court has determined to be incompetent to proceed and who remains incompetent for 3 years after the original determination, unless the charge is:

- Arson;
- Sexual battery;
- Robbery;
- Kidnapping;
- Aggravated child abuse;
- Aggravated abuse of an elderly person or disabled adult;
- Aggravated assault with a deadly weapon; murder;
- Manslaughter;
- Aggravated manslaughter of an elderly person or disabled adult;
- Aggravated manslaughter of a child;
- Unlawful throwing, projecting, placing, or discharging of a destructive device or bomb;
- Armed burglary;
- Aggravated battery;
- Aggravated stalking;
- A forcible felony as defined in s. 776.08, F.S., that is not otherwise listed;
- An offense involving the possession, use, or discharge of a firearm; or an attempt to commit any of these offenses;
- Any offense allegedly committed by a defendant who has had a forcible or violent felony conviction within the five years preceding the date of arrest for the nonviolent felony sought to be dismissed;
- Any offense allegedly committed by a defendant who, after having been found incompetent and under court supervision in a community-based program, is formally charged by a State Attorney with a new felony offense; or
- An offense for which there is an identifiable victim and the victim has not consented to the dismissal.

Psychotropic Medication Treatment

The bill requires jail physicians to provide a current psychotropic medication order at the time of an inmate's transfer to a forensic or civil facility. The bill authorizes an admitting physician at a state forensic or civil facility to continue the administration of psychotropic medication previously prescribed in jail, when a forensic client lacks the capacity to make an informed decision and, in the opinion of the physician, the abrupt cessation of medication could risk the health and safety of the client during the time a court order to medicate is pursued. This authority is for non-emergency situations and is limited to the time period required to obtain a court order for the medication. This provision applies to all forensic clients since it appears in the general provisions of ch. 916, F.S. Therefore, forensic clients who are either mentally ill, or have autism or mental retardation as a diagnosis would be subject to this provision when admitted to facilities operated by DCF or APD. Continuation of the medication could be beneficial as it may help prevent possible decompensation thereby potentially decreasing the client's length of stay in the facility.

The bill requires the administrator or designee of the civil or forensic facility to petition the committing court or the circuit court serving the county where the facility is located within 5 days of the inmate's admission, excluding weekends and legal holidays, for an order authorizing continued treatment.

B. SECTION DIRECTORY:

Section 1: Amends s. 916.107, F.S., relating to rights of forensic clients.
Section 2: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 3: Amends s. 916.145, F.S., relating to dismissal of charges.
Section 4: Amends s. 916.15, F.S., relating to involuntary commitment of defendant adjudicated not guilty by reason of insanity.
Section 5: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   This bill would have an insignificant impact on the state courts.

   The bill amends s. 916.145, F.S., allowing for the discretionary dismissal of charges against non-violent defendants found incompetent to proceed after 3 years instead of the current 5 years. If the charge is for an offense other than those serious crimes specifically enumerated in the bill, the court may dismiss the charges between 3 and 5 years after the determination that the defendant was incompetent to proceed. Allowing a shorter timeframe for dismissal of charges is likely to reduce the workload of the judiciary and the state courts system, as the criminal courts have to monitor and hold status hearings for these defendants until their charges are dismissed or competency is restored. The majority of these defendants are non-violent and on conditional release in community placements. Reducing the dismissal period for non-violent incompetent defendants would eliminate years of monitoring and status hearings by the criminal courts. The impact, if any, cannot be determined because the early dismissal provision is discretionary.[25]

[25] Office of the State Court Administrator, "CS/*HB 769 Judicial Impact Statement*", 01/25/2016, On file with the House Appropriations Committee.

The bill requires the courts to hold competency and commitment status hearings within 30 days after the court receives notice that the defendant is competent to proceed or no longer meets the criteria for continued commitment. There should be no impact to the judicial or court workload because the courts are already required to do so pursuant to Florida Rules of Criminal Procedure 3.212 and 3.218.[26]

Pursuant to s.916.106 F.S. the Department of Children and Families is responsible for the treatment of forensic clients who have been determined incompetent to proceed due to mental illness or who have been acquitted of a felony by reason of insanity. The bill requires transportation be provided by DCF for clients to the committing court's jurisdiction for competency and commitment status hearings. This should have no fiscal impact on the Department.[27]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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[26] *Id.*

[27] The Department of Children and Families, "*HB 769 Legislative Bill Analysis*", 11/20/2015, On file with the House Appropriations Committee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 13, 2016, the Children, Families & Seniors Subcommittee adopted an amendment to HB 769. The amendment:

- Permits a court to dismiss charges for specified nonviolent offenses for an individual whom the court has determined to be incompetent to proceed and who remains incompetent for 3 years after the original determination.
- Changes the timeframe for mandatory dismissal of all charges for an individual whom the court has determined to be incompetent to proceed and who remains incompetent to 5 continuous, uninterrupted years since the court's original determination of incompetency.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

1 A bill to be entitled
2 An act relating to mental health treatment; amending
3 s. 916.107, F.S.; provides for continuation of
4 psychotropic medication by forensic and civil
5 facilities for individuals receiving such medication
6 before admission; amending s. 916.13, F.S.; providing
7 a timeframe within which competency hearings must be
8 held; requiring that a defendant be transported for
9 the hearing; amending s. 916.145, F.S.; revising the
10 time for dismissal of certain charges for defendants
11 who remain incompetent to proceed to trial; providing
12 exceptions; amending s. 916.15, F.S.; providing a
13 timeframe within which commitment hearings must be
14 held; requiring that a defendant be transported for
15 the hearing; providing an effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. Paragraph (a) of subsection (3) of section
20 916.107, Florida Statutes, is amended to read:
21 916.107 Rights of forensic clients.—
22 (3) RIGHT TO EXPRESS AND INFORMED CONSENT.—
23 (a) A forensic client shall be asked to give express and
24 informed written consent for treatment. If a client refuses such
25 treatment as is deemed necessary and essential by the client's
26 multidisciplinary treatment team for the appropriate care of the

27 client, such treatment may be provided under the following
28 circumstances:
29 1. In an emergency situation in which there is immediate
30 danger to the safety of the client or others, such treatment may
31 be provided upon the written order of a physician for up to ~~a~~
32 ~~period not to exceed~~ 48 hours, excluding weekends and legal
33 holidays. If, after the 48-hour period, the client has not given
34 express and informed consent to the treatment initially refused,
35 the administrator or designee of the civil or forensic facility
36 shall, within 48 hours, excluding weekends and legal holidays,
37 petition the committing court or the circuit court serving the
38 county in which the facility is located, at the option of the
39 facility administrator or designee, for an order authorizing the
40 continued treatment of the client. In the interim, the need for
41 treatment shall be reviewed every 48 hours and may be continued
42 without the consent of the client upon the continued written
43 order of a physician who has determined that the emergency
44 situation continues to present a danger to the safety of the
45 client or others.
46 2. In a situation other than an emergency situation, the
47 administrator or designee of the facility shall petition the
48 court for an order authorizing necessary and essential treatment
49 for the client.
50 a. If the client has been receiving psychotropic
51 medication at the jail at the time of transfer to the forensic
52 or civil facility and lacks the capacity to make an informed

53 decision regarding mental health treatment at the time of
54 admission, the admitting physician shall order continued
55 administration of psychotropic medication if, in the clinical
56 judgment of the physician, abrupt cessation of that psychotropic
57 medication could pose a risk to the health or safety of the
58 client while a court order to medicate is pursued. The
59 administrator or designee of the forensic or civil facility
60 shall, within 5 days after a client's admission, excluding
61 weekends and legal holidays, petition the committing court or
62 the circuit court serving the county in which the facility is
63 located, at the option of the facility administrator or
64 designee, for an order authorizing the continued treatment of a
65 client with psychotropic medication. The jail physician shall
66 provide a current psychotropic medication order at the time of
67 transfer to the forensic or civil facility or upon request of
68 the admitting physician after the client is evaluated.
69 b. The court order shall allow such treatment for up to ~~a~~
70 ~~period not to exceed~~ 90 days after ~~following~~ the date that ~~of~~
71 ~~the entry of~~ the order was entered. Unless the court is notified
72 in writing that the client has provided express and informed
73 written consent ~~in writing~~ or that the client has been
74 discharged by the committing court, the administrator or
75 designee of the facility shall, before the expiration of the
76 initial 90-day order, petition the court for an order
77 authorizing the continuation of treatment for an additional 90
78 days ~~another 90-day period~~. This procedure shall be repeated

79 until the client provides consent or is discharged by the
80 committing court.
81 3. At the hearing on the issue of whether the court should
82 enter an order authorizing treatment for which a client was
83 unable to or refused to give express and informed consent, the
84 court shall determine by clear and convincing evidence that the
85 client has mental illness, intellectual disability, or autism,
86 that the treatment not consented to is essential to the care of
87 the client, and that the treatment not consented to is not
88 experimental and does not present an unreasonable risk of
89 serious, hazardous, or irreversible side effects. In arriving at
90 the substitute judgment decision, the court must consider at
91 least the following factors:
92 a. The client's expressed preference regarding treatment;
93 b. The probability of adverse side effects;
94 c. The prognosis without treatment; and
95 d. The prognosis with treatment.
96
97 The hearing shall be as convenient to the client as may be
98 consistent with orderly procedure and shall be conducted in
99 physical settings not likely to be injurious to the client's
100 condition. The court may appoint a general or special magistrate
101 to preside at the hearing. The client or the client's guardian,
102 and the representative, shall be provided with a copy of the
103 petition and the date, time, and location of the hearing. The
104 client has the right to have an attorney represent him or her at

105 the hearing, and, if the client is indigent, the court shall
106 appoint the office of the public defender to represent the
107 client at the hearing. The client may testify or not, as he or
108 she chooses, and has the right to cross-examine witnesses and
109 may present his or her own witnesses.
110 Section 2. Subsection (2) of section 916.13, Florida
111 Statutes, is amended to read:
112 916.13 Involuntary commitment of defendant adjudicated
113 incompetent.—
114 (2) A defendant who has been charged with a felony and who
115 has been adjudicated incompetent to proceed due to mental
116 illness, and who meets the criteria for involuntary commitment
117 ~~to the department~~ under ~~the provisions of~~ this chapter, may be
118 committed to the department, and the department shall retain and
119 treat the defendant.
120 (a) Within ~~No later than~~ 6 months after the date of
121 admission and at the end of any period of extended commitment,
122 or at any time the administrator or designee determines ~~shall~~
123 ~~have determined~~ that the defendant has regained competency to
124 proceed or no longer meets the criteria for continued
125 commitment, the administrator or designee shall file a report
126 with the court pursuant to the applicable Florida Rules of
127 Criminal Procedure.
128 (b) A competency hearing shall be held within 30 days
129 after the court receives notification that the defendant is
130 competent to proceed or no longer meets the criteria for

131 continued commitment. The defendant must be transported to the
132 committing court's jurisdiction for the hearing.
133 Section 3. Section 916.145, Florida Statutes, is amended
134 to read:
135 (Substantial rewording of section. See
136 s. 916.145, F.S., for present text.)
137 916.145 Dismissal of charges.—
138 (1) The charges against a defendant adjudicated
139 incompetent to proceed due to mental illness shall be dismissed
140 without prejudice to the state if the defendant remains
141 incompetent to proceed for 5 continuous, uninterrupted years
142 after such determination, unless the court in its order
143 specifies its reasons for believing that the defendant will
144 become competent to proceed within the foreseeable future and
145 specifies the time within which the defendant is expected to
146 become competent to proceed. The court may dismiss such charges
147 after at least 3 years but not more than 5 years after such
148 determination, unless the charge is:
149 (a) Arson;
150 (b) Sexual battery;
151 (c) Robbery;
152 (d) Kidnapping;
153 (e) Aggravated child abuse;
154 (f) Aggravated abuse of an elderly person or disabled
155 adult;
156 (g) Aggravated assault with a deadly weapon;

157 (h) Murder;
158 (i) Manslaughter;
159 (j) Aggravated manslaughter of an elderly person or
160 disabled adult;
161 (k) Aggravated manslaughter of a child;
162 (l) Unlawful throwing, projecting, placing, or discharging
163 of a destructive device or bomb;
164 (m) Armed burglary;
165 (n) Aggravated battery;
166 (o) Aggravated stalking;
167 (p) A forcible felony as defined in s. 776.08 and not
168 listed elsewhere in this subsection;
169 (q) An offense where an element of the offense requires
170 the possession, use, or discharge of a firearm;
171 (r) An attempt to commit an offense listed in this
172 subsection;
173 (s) An offense allegedly committed by a defendant who has
174 had a forcible or violent felony conviction within the 5 years
175 immediately preceding the date of arrest for the nonviolent
176 felony sought to be dismissed;
177 (t) An offense allegedly committed by a defendant who,
178 after having been found incompetent and placed under court
179 supervision in a community-based program, is formally charged by
180 a state attorney or the Office of the Statewide Prosecutor with
181 a new felony offense; or
182 (u) An offense for which there is an identifiable victim

183 and such victim has not consented to the dismissal.
184 (2) This section does not prohibit the state from refiling
185 dismissed charges if the defendant is declared to be competent
186 to proceed in the future.
187 Section 4. Subsection (5) is added to section 916.15,
188 Florida Statutes, to read:
189 916.15 Involuntary commitment of defendant adjudicated not
190 guilty by reason of insanity.—
191 (5) The commitment hearing shall be held within 30 days
192 after the court receives notification that the defendant no
193 longer meets the criteria for continued commitment. The
194 defendant must be transported to the committing court's
195 jurisdiction for the hearing.
196 Section 5. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 873 Special Facility Construction Account
SPONSOR(S): Appropriations Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Appropriations Committee		Heflin	Leznoff

SUMMARY ANALYSIS

The bill modifies requirements for education fixed capital outlay funding for school districts and public charter schools. Specifically the bill replaces the existing eligibility criteria for charter school outlay funding. To bill provides that to be eligible for charter school capital outlay funding, a charter school must:

- Be in operation for 2 or more years;
- Not have more than two consecutive school grades lower than "B" unless the school serves a student population at least 50 percent of which is eligible for free or reduced-price meals; and
- Have an annual audit with no financial emergency conditions; or
- Be part of a high-performing charter school system.

Additionally, a charter school must have received final approval from its sponsor for operation during that fiscal year and may not operate in facilities provided by the sponsor in order to receive capital outlay funding.

The bill also eliminates provisions granting priority for funding to charter schools that received capital outlay funding in FY 2005-06 and revises the methodology for calculating the amount of state funding for charter school capital outlay from 1/15th to 1/40th of the cost per student station. If state funds for charter school capital outlay do not fully fund 1/40th of the cost per student station or the amount of per student funding generated by the district school board's discretionary ad valorem tax levy for capital outlay, whichever is less, then the school district must share discretionary ad valorem tax revenues to make up the difference.

The bill also modifies current law regarding the Special Facility Construction Account (SFCA), which provides construction funds to school districts which have urgent construction needs but lack sufficient resources, to incorporate technical changes suggested by the Department of Education as well as recommendations by the Office of Program Policy Analysis and Government Accountability (OPPAGA) to improve the effectiveness of the construction projects funded by the SFCA. Specifically, the bill:

- Modifies school district participation requirements pertaining to new construction funding and discretionary capital improvement millage funding.
- Changes the annual deadline for district school boards to certify final phase construction plans as complete and in compliance with the required codes.
- Specifies that a representative of the department must chair the Special Facility Construction Committee (SFCC); and
- Modifies requirements relating to application review, student enrollment projections, educational plant surveys, and project cost overruns.

Changes are also made to the requirements for school district construction costs. The bill:

- Changes the revenue sources which are not allowed to be expended in amounts above the statutory costs per student station to include all capital outlay revenue sources available to school districts;
- Restricts school district eligibility for state Public Capital Outlay and Debt Service Trust Fund (PECO) appropriations for three years if the district exceeds the statutory cost per student station for school construction projects; and
- Requires the Department of Education (DOE) and the Office of Economic and Demographic Research (EDR) to work in consultation to study the actual costs of construction and submit recommendations to the legislation on new statutory costs per student station for school construction projects.

HB 5001, Specific Appropriation 19 of the House 2016-2017 General Appropriations Act (GAA), provides $90 million in state appropriations for charter school capital outlay. If the GAA were finalized with the $90 million appropriation, school districts would be required to provide payments totaling $62.9 million to charter schools from the local ad valorem revenues generated from the 1.5 mill levy. *See* Fiscal Comments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Charter School Capital Outlay

Present Situation

To be eligible for charter school capital outlay funding, a charter school must:

- Have been in operation for at least three years, be governed by a governing board established in Florida for three or more years which operates both charter schools and conversion charter schools within the state, be part of an expanded feeder chain[1] with an existing charter school in the district that is currently receiving charter school capital outlay funds, be accredited by the Commission on Schools of the Southern Association of Colleges and Schools, or serve students in facilities that are provided by a business partner for a charter school-in-the-workplace;
- Demonstrate financial stability for future operation as a charter school;
- Have satisfactory student achievement based upon the state accountability standards applicable to charter schools;
- Have received final approval from its sponsor for operation during that fiscal year; and
- Serve students in facilities that are not provided by the charter school sponsor.[2]

Capital outlay funds may be used by a charter school's governing board for the:

- Purchase of real property.
- Construction of school facilities.
- Purchase, lease-purchase, or lease of permanent or relocatable school facilities.
- Purchase of vehicles to transport students to and from the charter school.
- Renovation, repair, and maintenance of school facilities that the charter school owns or is purchasing through a lease-purchase or long-term lease of five years or longer.
- Purchase, lease-purchase, or lease of new and replacement equipment, and enterprise resource software applications.[3]
- Payment of the cost of premiums for property and casualty insurance necessary to insure the school facilities.
- Purchase, lease-purchase, or lease of driver's education vehicles, motor vehicles used for the maintenance or operation of plants and equipment, security vehicles, or vehicles used in storing or distributing materials and equipment.[4]

Charter school capital outlay funding is allocated based upon the following priorities:

- First priority is given to charter schools that received capital outlay funding in FY 2005-06. Such a school receives the same per-student amount that it received in FY 2005-06 up to the lesser of:

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[1] A charter school may be considered a part of an expanded feeder chain under s. 1013.62, F.S., if it either sends or receives a majority of its students directly to or from a charter school that is currently receiving capital outlay funding pursuant to Section 1013.62, F.S. Rule 6A-2.0020 (1), F.A.C.

[2] Section 1013.62(1)(a), F.S. A conversion charter school, i.e., a charter school created by the conversion of an existing public school to charter status, is not eligible for capital outlay funding if it operates in facilities provided by its sponsor at no charge or for a nominal fee or if it is directly or indirectly operated by the school district. Section 1013.62(1)(d), F.S.

[3] Enterprise resource software applications must be "classified as capital assets in accordance with definitions of the Governmental Accounting Standards Board, have a useful life of at least 5 years, and are used to support schoolwide administration or state-mandated reporting requirements." Section 1013.62(2)(f), F.S.

[4] Section 1013.62(2)(a)-(h), F.S.

- The actual number of students enrolled in the current year; or
- The number of students enrolled in FY 2005-06.

- After calculating the first priority, remaining funds are allocated with the same per-student amount to:
  - Those schools not included in the first priority allocation; and
  - Those schools in the first priority allocation with growth in excess of FY 2005-06 student enrollments.

Any excess funds remaining after the first and second priority calculations are allocated among all eligible charter schools.[5]

Each charter school's capital outlay allocation must not exceed 1/15th of the statutory cost per student station. Based on the December 22, 2015 PECO Revenue Estimating Conference, the cost per student station was $21,407 for an elementary school, $23,117 for a middle school, and $30,027 for a high school. The cost per student station is adjusted annually to reflect increases or decreases in the Consumer Price Index.[6] DOE must disburse these funds to the sponsoring school district monthly based upon 1/12th of the amount that it expects the charter school to receive during that fiscal year. The funding amount is recalculated during the fiscal year to reflect fluctuations in student enrollment indicated by the second and third enrollment surveys and impacts on available funds resulting from charter school closings and the addition of newly eligible charter schools.[7]

In the most recent five fiscal years, the Legislature appropriated the following charter school capital outlay funds:

Charter School Capital Outlay Appropriations[8]

Fiscal Year	Appropriation	Total Charter Schools Funded	First Priority	Second Priority
2011-12	$55.2 million[9]	372	151	221
2012-13	$55.2 million[10]	432	144	288
2013-14	$90.6 million[11]	473	138	335
2014-15	$75.0 million[12]	487	133	354
2015-16	$50.0 million[13]	535	135	400

In addition to the appropriated state funds for charter school capital outlay, the law authorizes, but does not require, school boards to allocate local discretionary capital improvement funds to charter schools.[14]

Effect of Proposed Changes

The bill replaces the existing eligibility criteria for charter school outlay funding. To be eligible for charter school capital outlay funding, a charter school must:

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[5] Section 1013.62(1)(b), F.S.
[6] Sections 1013.62(1)(c), and 1013.64(6)(b), F.S. Adjusted cost per student station may be found *at* http://edr.state.fl.us/Content/conferences/peco/archives/141209peco.pdf.
[7] Section 1013.62(1)(f), F.S.
[8] School totals provided by FDOE. Email, Office of Independent Education and Parental Choice (Sept. 17, 2014).
[9] Specific Appropriation 15A, s. 2, ch. 2011-69, L.O.F.
[10] Specific Appropriation 16, s. 2, ch. 2012-118, L.O.F.
[11] Specific Appropriation 18, s. 2, ch. 2013-40, L.O.F.
[12] Specific Appropriation 25, s. 2, ch. 2014-51, L.O.F.
[13] Specific Appropriation 18, s. 2, ch. 2015-232, L.O.F.
[14] Section 1011.71(2), F.S.

- Be in operation for 2 or more years;
- Not have more than two consecutive school grades lower than "B" unless the school serves a student population at least 50 percent of which is eligible for free or reduced-price meals; and
- Have an annual audit with no financial emergency conditions; or
- Be part of a high-performing charter school system.

Additionally, a charter school must have received final approval from its sponsor for operation during that fiscal year and may not operate in facilities provided by the sponsor in order to receive capital outlay funding.

Additionally, the bill eliminates provisions granting priority for funding to charter schools that received capital outlay funding in FY 2005-06. The bill revises the methodology for calculating the amount of state funding for charter school capital outlay from 1/15th to 1/40th of the cost per student station. If state funds for charter school capital outlay do not fully fund 1/40th of the cost per student station or the amount of per student funding generated by the district school board's discretionary ad valorem tax levy for capital outlay, whichever is less, then the school district must share discretionary ad valorem tax revenues to make up the difference.

The bill adds as allowable uses of capital outlay funds, for both charter schools and non-charter public schools, the purchase or lease of computer hardware necessary for gaining access to electronic content or to serve purposes specified in the charter schools and non-charter public schools digital classrooms plan. Charter schools are also aligned with non-charter public schools to allow payment of the cost of the opening day collection for the library media center of a new school.

Special Facilities Construction Account

Present Situation

The SFCA is established as part of the PECO Trust Fund to provide construction funds to school districts that have urgent construction needs but lack sufficient resources, and has no reasonable expectation of raising the needed funds over the next three years from authorized sources of capital outlay revenue.[15] A district may not receive funds for more than one approved project in any 3-year period.[16] The department must encourage a construction program that reduces the average size of schools in the district.[17]

Typically, the projects that receive funds through the SFCA are located in rural areas and that have an insufficient tax base to fund large construction projects.[18] The state's smaller school districts, which serve fewer than 20,000 students, generally raise considerably less through local discretionary property taxes than larger Florida school districts.[19] To improve the effectiveness of programs funded by the SFCA, a recent report by the Office of Program Policy Analysis and Government Accountability recommended the relevant statutes be modified to:

- Clarify the types of projects that are eligible for funding.
- Clarify the department's rule in making funding decisions.
- Require that the department conduct educational plant surveys.
- Require the department to approve the final construction plans for funded projects.
- Change the membership of the project selection committee; and

[15] Section 1013.64(2)(a), F.S.
[16] *Id.*
[17] *Id.*
[18] Office of Program Policy Analysis and Government Accountability, *Special Facility Construction Projects Appear Needed, but Have Excess Capacity* (Report No. 11-02), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1102rpt.pdf, at 1.
[19] *Id.*

- Require districts to levy the maximum discretionary millage prior to their application.[20]

District Effort and Participation Requirement

To receive funds from the SFCA, districts must, at the time of request for funds and for a continuing period of 3 years, levy the maximum millage against their nonexempt assessed property value or raise an equivalent amount of revenue from the school capital outlay surtax.[21] Additionally, districts must apply unencumbered Capital Outlay and Debt Service funds, PECO new construction funds, and discretionary capital improvement millage funds to the project.[22] The district must also forego all other fixed capital outlay funding for a period of 3 years.[23] This leaves participating districts with limited ability to pay for other fixed capital outlay needs.

Construction Plans

District school boards must certify that final phase III construction plans are complete and in compliance with the building and life safety codes before August 1.[24] This deadline does not provide the department sufficient time to review the construction plans before such plans are considered by the Special Facility Construction Committee (SFCC). Small districts do not have the expertise to determine if an architect used the most cost-effective school design or overbuilt the school. As a result, such districts may not identify features that do not add value or may incur controllable cost overruns.[25]

Special Facility Construction Committee

The SFCC is responsible for a preapplication review of a school district's funding requests for special facility construction projects. The SFCC is composed of:

- Two department representatives;
- A representative from the Governor's office;
- A representative selected annually by the district school boards; and
- A representative selected annually by the superintendents.[26]

The law does not specify which representative serves as the committee chair but in practice a department representative serves this role.[27] Additionally, the law authorizes a project review subcommittee, convened by the SFCC, to review preapplications.[28] The subcommittee is composed of:

- Two department representatives; and
- Two staff from school districts that are not eligible to participate in the Special Facility Construction program.[29]

The SPCC and the subcommittee evaluate the ability of the projects to relieve critical needs and rank the requests in priority order.[30] The statewide priority list for special facilities construction must be submitted to the Legislature in the Commissioner of Education's annual capital outlay legislative budget request at least 45 days before the legislative session.[31]

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[20] *Id* at 12.
[21] Section 1013.64(2)(a)8., F.S.
[22] Section 1013.64(2)(a)11., F.S.
[23] *Id.*
[24] Section 1013.64(2)(a)12., F.S.
[25] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 3.
[26] Section 1013.64(2)(b), F.S.
[27] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 3.
[28] Section 1013.64(2)(a)1., F.S.
[29] *Id.*
[30] Section 1013.64(2)(a)1. and (c), F.S.
[31] Section 1013.64(2)(c), F.S.

Application Review

Within 60 days after receiving the preapplication review request, the SFCC or subcommittee must meet in the school district to review the project proposal and existing facilities.[32] The law, however, does not specify a deadline for the school districts to submit the preapplications for review by the committee or subcommittee.[33] In practice, to meet the deadline for the commissioner to submit the capital outlay legislative budget request, the department convenes the committee meeting in August of each year.[34]

Determining Critical Need

To determine whether a school district's proposed construction project is a critical need, the SFCC or subcommittee must consider:

- The capacity of all existing facilities within the district as determined by the Florida Inventory of School Houses;
- The district's pattern of student growth; and
- The district's existing and projected capital outlay full-time equivalent student enrollment as determined by the department.

Laws governing educational facilities plans[35] require such plans to be based on demographic, revenue, and education estimating conferences.[36]

Educational Plant Surveys

To be considered for funding through the SFCA, the construction project must be recommended in the most recent survey or surveys by the school district under the rules of the State Board of Education.[37] School districts may:

- Contract with a private consultant to conduct the educational plant surveys,
- Request the department to conduct facility reviews; or
- Conduct the surveys in-house.[38]

Since 1998, school districts have hired private consultants to conduct surveys for 19 of the 24 projects that received funding through the SFCA, "in part, because the districts believed this provided an independent, third-party assessment of their facilities' needs."[39] Often these consultants also worked for firms that designed or constructed the facilities.[40] Between 2010 and 2015, 13 school districts requested funding, which included 5 districts that contracted with private consultants to conduct the educational plant surveys.[41]

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[32] *Id.*
[33] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 3.
[34] *Id.*
[35] Sections 1013.31 and 1013.35(2)(a)1., F.S.
[36] *Id.*
[37] Section 1013.64(2)(a)2., F.S.
[38] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 4.
[39] Office of Program Policy Analysis and Government Accountability, *Special Facility Construction Projects Appear Needed, but Have Excess Capacity* (Report No. 11-02), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1102rpt.pdf, at 8.
[40] *Id.*
[41] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 4.

Project Cost Overruns

SFCA Project costs are limited by the statutorily established maximum cost per student station.[42] However, the law is silent regarding cost increases and changes in project scope.[43] The department identified three projects since 1998 in which the final cost exceeded the amount that the committee originally approved.[44]

Effect of Proposed Changes

The bill modifies current law regarding the SFCA to incorporate technical changes suggested by the department and options recommended by OPPAGA to improve the effectiveness of the construction projects funded by the SFCA.[45]

The bill preserves the prohibition on a school district from receiving SFCA funding for more than one approved project within a 3-year period. However, the bill extends this prohibition to any time during which any portion of the district's participation requirement remains outstanding. As a result, this modification may help to allocate SFCA funds for targeted construction projects to meet critical need.

District Effort and Participation Requirement

The bill clarifies that a school district's participation requirement is equivalent to all unencumbered and future revenue acquired during a 3-year period, beginning with the year of the initial appropriation and the next two years from Capital Outlay and Debt Service funding, PECO new construction funding, and discretionary capital improvement millage funding. In addition, the bill:

- Requires that beginning in the 2019-2020 fiscal year, a school district seeking SFCA funding for a construction project must have levied the maximum discretionary capital improvement millage against its nonexempt assessed property value, as authorized in law,[46] or an equivalent amount of revenue from the school capital outlay sales surtax, as authorized in law,[47] for a minimum of three years prior to the request and for a continuing period necessary to meet the district's participation requirement;
- Removes the requirement that a school district's participation requirement be satisfied within a 3-year period.
- Reduces from 1.5 mills to 1.0 mill, the value of the discretionary capital improvement millage that a school district with a new or active project must budget annually until the district's participation requirement is met.

A district school board must set the discretionary capital improvement millage levy rate at a public meeting. The school capital outlay surtax is subject to approval by voter referendum.[48]

Construction Plans

The bill makes June 1 the annual deadline for the district school boards to certify their final phase III construction plans as complete and in compliance with the building and life safety codes. This

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[42] Section 1013.62(6)(b)1., F.S., *see also* Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 4. Cost per student station includes contract costs, legal and administrative costs, fees of architects and engineers, furniture and equipment, and site improvement costs. Cost per student station does not include the cost of purchasing or leasing the site for the construction or the cost of related offsite improvements. Section 103.64(6), F.S.
[43] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 4.
[44] Office of Program Policy Analysis and Government Accountability, *Special Facility Construction Projects Appear Needed, but Have Excess Capacity* (Report No. 11-02), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1102rpt.pdf, at 11.
[45] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 3.
[46] Section 1011.71(2), F.S.
[47] Section 212.055(6), F.S.
[48] *Id.*

modification addresses an existing issue regarding insufficient time for the department to review the construction plans before such plans are considered by the SFCC. The modified deadline will allow the department to:

- Review the construction plans before convening the committee meeting in August of each year; and
- Advise the committee whether the construction plans are economical and compliant with the required codes.[49]

Special Facility Construction Committee

The bill codifies current practice by specifying that a representative of the department must chair the SFCC. This modification will allow the department to designate one of its two representatives to the SFCC to serve as the committee chair. The bill does not alter the composition of either the SFCC or the project review subcommittee.

Application Review

The bill specifies that a school district may request a preapplication review of the district's construction project proposal at any time. However, if the district school board seeks inclusion in the department's next annual capital outlay legislative budget request, the district must make the preapplication review request before February 1 of the fiscal year before the legislative budget request.

Additionally, the bill changes the deadline for the committee or subcommittee to complete the preapplication review from 60 days to 90 days after receiving the preapplication review request.

Determining Critical Need

The bill modifies the way the SFCC and project review subcommittee determines whether a proposed construction project is a critical need. The bill requires the use of capital outlay enrollment projections that are based on demographic, revenue, and education estimating conferences rather than the enrollment projections determined by the department. This modification aligns the change in projecting student enrollment to existing laws governing educational facilities plans.[50]

Educational Plant Surveys

The bill requires proposed special facility construction projects to be included in the most recent survey or survey amendment that is collaboratively prepared by a school district seeking SFCA funding and the department. This modification will allow the department to better assess the need for special facility construction projects and provide assurance to other school districts and the general public that the SFCA funds are spent on critically needed capital projects.[51]

The bill also precludes a district, in preparation of a survey, from using a consultant who is employed by or receiving compensation from a third party that designs or constructs a project recommended by the survey.

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[49] Florida Department of Education, 2016 Agency Legislative Bill Analysis for SB 1064 (Dec. 4, 2015), at 5.
[50] *Id.*
[51] *Id.*

Project Cost Overruns

The bill authorizes SFCA funds to be used to pay for cost overruns necessitated by a disaster as defined in law[52] or an unforeseeable circumstance beyond the district's control as determined by the SFCC.

School District Construction Costs

Present Situation

Section 1013.64(5)(2), F.S., limits the cost of school district capital outlay projects to the following student station costs:

- $17,952 for an elementary school;
- $19,386 for a middle school; and
- $25,181 for a high school.

These costs were established in 2006, and the statute provides for an annual adjustment each year by the Office of Economic and Demographic research based on the Consumer Price Index.[53] The site cost and offsite improvement costs are not included in the cost per student station. School districts are not required to adhere to these cost maximums when using sales surtax proceeds authorized in s. 212.055, F.S., proceeds from revenue bonds authorized in s. 17, Art. XII of the State Constitution, or voted ad valorem property tax proceeds authorized by a referendum of the general electorate[54]. School districts that exceed the cost maximums are required to report the reasons for the excess costs to the department. The department is required to provide this information to the Legislature each year by December 31.

Effect of Proposed Legislation

The bill requires the department to work in consultation with the Office of Economic and Demographic Research to conduct a study of the statutory cost per student station amounts using the most recent available information on construction costs. The department shall report the final results of the analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives by March 1, 2017. The bill also prohibits school districts from spending more than the cost per student station from any available revenue sources. The site cost and offsite improvement costs are required to be included in the cost per student station. A district that exceeds the statutory student station costs shall be ineligible for allocations from the PECO Trust Fund for the next three years in which the district would have received allocations had the violation not occurred.

B. SECTION DIRECTORY:

Section 1. Amends s. 1011.71, F.S., providing for the calculation and payment of capital outlay funding to charter schools; and providing that enterprise resource software may be acquired by certain means.

Section 2. Amends s. 1013.62, F.S., revising eligibility requirements for charter school capital outlay funding; revising charter school funding allocations; revising the list of approved uses of charter school capital outlay funds.

Section 3. Amends s. 1013.64, F.S., providing that a school district may not receive funds from the Special Facility Construction Account under certain circumstances; revising the criteria for a request for

[52] Section 252.34, F.S.
[53] Based on the December 22, 2015 Public Education Capital Outlay (PECO) Revenue Estimating Conference, the cost per student station is $21,407 for an elementary school, $23,117 for a middle school, and $30,027 for a high school. Adjusted cost per student station may be found *at* http://edr.state.fl.us/Content/conferences/peco/archives/141209peco.pdf.
[54] Section 1011.73, F.S.

funding; authorizing the request for a preapplication review to take place at any time; providing exceptions; revising the time period for completion of the review; providing that certain capital outlay full-time equivalent student enrollment estimates be determined by specified estimating conferences; requiring surveys to be cooperatively prepared by certain entities and approved by the Department of Education; prohibiting certain consultants from specified employment and compensation; requiring the cost per student station to include certain cost overruns; requiring a school district to levy the maximum millage against certain property value or raise a specified amount from the school capital outlay surtax under certain circumstances; reducing the required millage to be budgeted for a project; requiring certain plans to be finalized by a specified date; requiring a representative of the department to chair the Special Facility Construction Committee; prohibiting district school boards from using certain funds for new construction of educational plant space that exceeds maximum thresholds for cost per student station after a specified date; prohibiting new construction initiated after a specified date by a district school board from exceeding the maximum thresholds; providing that school districts that exceed the maximum thresholds are ineligible for certain allocations for a specified period; revising the costs included in calculating the maximum thresholds; and requiring the department to conduct a study of the total cost per student station and provide a report to the Governor and Legislature by a certain date.

Section 4. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill prohibits school districts from spending more than the cost per student station from any available revenue sources. A district that exceeds the statutory student station costs shall be ineligible for allocations from the PECO Trust Fund for the next three years in which the district would have received allocations had the violation not occurred.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill amends s. 1011.71, F.S., relating to district school tax and s. 1013.62, F.S., relating to charter school capital outlay funding. The bill changes the methodology for calculating the amount of funding that shall be provided from state funds for charter school capital outlay from 1/15th to 1/40th of the cost per student station provided in s. 1013.64, F.S. Based on current capital outlay FTE estimates and the January 2016 cost per student station, total funding required at the 1/40th level is estimated to be $157.9 million. The bill requires school boards to provide to charter schools a portion of the funding generated by the 1.5 mills levied for capital outlay funding if the amount of state funding provided for

charter school capital outlay is insufficient to fully fund the 1/40th of the cost per student station or the amount of funding per student generated by the levy of local ad valorem for capital outlay, whichever is less. HB 5001, Specific Appropriation 19 of the House 2016-2017 General Appropriations Act (GAA), provides $90 million in state appropriations for charter school capital outlay. If the GAA were finalized with the $90 million appropriation, school districts would be required to provide payments totaling $62.9 million to charter schools from the local ad valorem revenues generated from the 1.5 mill levy.[55]

The bill requires proposed special facility construction projects to be included in the most recent survey or survey amendment that is collaboratively prepared by a school district seeking SFCA funding and the department. This modification will allow the department to better assess the need for special facility construction projects and provide assurance to other school districts and the general public that the SFCA funds are spent on critically needed capital projects.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[55] The amount is less than the remaining balance of $67.9 million due to some charter schools potentially receiving more than the school district local ad valorem revenue per student at the full 1/40th calculated amount. The bill provides for the amount of the 1/40th or the amount the district generates per fixed capital outlay student from the local ad valorem revenue. Charter schools in sixteen districts would receive the lesser amount of the revenue generated by the district's local ad valorem revenue. Those districts are: Clay, Columbia, Dixie, Escambia, Gadsden, Glades, Hernando, Hillsborough, Levy, Madison, Marion, Osceola, Pasco, Polk, Putnam, Santa Rosa, and Wakulla.

1 A bill to be entitled
2 An act relating to education funding; amending s.
3 1011.71, F.S.; providing for the calculation and
4 payment of capital outlay funding to charter schools;
5 providing that enterprise resource software may be
6 acquired by certain means; amending s. 1013.62, F.S.;
7 revising eligibility requirements for charter school
8 capital outlay funding; revising charter school
9 funding allocations; revising the list of approved
10 uses of charter school capital outlay funds; amending
11 s. 1013.64, F.S.; providing that a school district may
12 not receive funds from the Special Facility
13 Construction Account under certain circumstances;
14 revising the criteria for a request for funding;
15 authorizing the request for a preapplication review to
16 take place at any time; providing exceptions; revising
17 the time period for completion of the review;
18 providing that certain capital outlay full-time
19 equivalent student enrollment estimates be determined
20 by specified estimating conferences; requiring surveys
21 to be cooperatively prepared by certain entities and
22 approved by the Department of Education; prohibiting
23 certain consultants from specified employment and
24 compensation; requiring the cost per student station
25 to include certain cost overruns; requiring a school
26 district to levy the maximum millage against certain

27 property value or raise a specified amount from the
28 school capital outlay surtax under certain
29 circumstances; reducing the required millage to be
30 budgeted for a project; requiring certain plans to be
31 finalized by a specified date; requiring a
32 representative of the department to chair the Special
33 Facility Construction Committee; prohibiting district
34 school boards from using certain funds for new
35 construction of educational plant space that exceeds
36 maximum thresholds for cost per student station after
37 a specified date; prohibiting new construction
38 initiated after a specified date by a district school
39 board from exceeding the maximum thresholds; providing
40 that school districts that exceed the maximum
41 thresholds are ineligible for certain allocations for
42 a specified period; revising the costs included in
43 calculating the maximum thresholds; requiring the
44 department to conduct a study of the total cost per
45 student station and provide a report to the Governor
46 and Legislature by a certain date; providing an
47 effective date.
48
49 Be It Enacted by the Legislature of the State of Florida:
50
51 Section 1. Subsection (2) of section 1011.71, Florida
52 Statutes, is amended to read:

53 1011.71 District school tax.—
54 (2) In addition to the maximum millage levy as provided in
55 subsection (1), each school board may levy not more than 1.5
56 mills against the taxable value for school purposes for district
57 schools, including charter schools. A charter school shall be
58 provided an amount equal to the remaining balance of funding
59 needed to achieve the amount of the state funding allocation
60 provided in s. 1013.62 after the amount of state appropriations
61 is deducted. Annually, by December 30, the department shall
62 calculate the amount of payments to eligible charter schools
63 using the certified taxable value and millage rate as provided
64 in the TRIM notice pursuant to s. 200.065 and certify to each
65 school district the amount the school district must pay to each
66 charter school based on the remaining balance of funding needed
67 to achieve the amount of the state funding allocation as
68 provided in s. 1013.62 after the amount of state appropriations
69 is deducted. School districts shall make payments to charter
70 schools no later than February 1 of each year, beginning on
71 February 1, 2017, for the 2016-2017 fiscal year. Revenues
72 retained by a school district after payments are made to charter
73 schools may be used by the school district ~~at the discretion of~~
74 ~~the school board,~~ to fund:
75 (a) New construction and remodeling projects, as set forth
76 in s. 1013.64(3)(b) and (6)(b) and included in the district's
77 educational plant survey pursuant to s. 1013.31, without regard
78 to prioritization, sites and site improvement or expansion to

79 new sites, existing sites, auxiliary facilities, athletic
80 facilities, or ancillary facilities.
81 (b) Maintenance, renovation, and repair of existing school
82 plants or of leased facilities to correct deficiencies pursuant
83 to s. 1013.15(2).
84 (c) The purchase, lease-purchase, or lease of school
85 buses.
86 (d) The purchase, lease-purchase, or lease of new and
87 replacement equipment; computer hardware, including electronic
88 hardware and other hardware devices necessary for gaining access
89 to or enhancing the use of electronic content and resources or
90 to facilitate the access to and the use of a school district's
91 digital classrooms plan pursuant to s. 1011.62, excluding
92 software other than the operating system necessary to operate
93 the hardware or device; and enterprise resource software
94 applications that are classified as capital assets in accordance
95 with definitions of the Governmental Accounting Standards Board,
96 have a useful life of at least 5 years, and are used to support
97 districtwide administration or state-mandated reporting
98 requirements. <u>Enterprise resource software may be acquired by</u>
99 <u>annual license fees, maintenance fees, or lease agreements.</u>
100 (e) Payments for educational facilities and sites due
101 under a lease-purchase agreement entered into by a district
102 school board pursuant to s. 1003.02(1)(f) or s. 1013.15(2), not
103 exceeding, in the aggregate, an amount equal to three-fourths of
104 the proceeds from the millage levied by a district school board

105 pursuant to this subsection. The three-fourths limit is waived
106 for lease-purchase agreements entered into before June 30, 2009,
107 by a district school board pursuant to this paragraph.
108 (f) Payment of loans approved pursuant to ss. 1011.14 and
109 1011.15.
110 (g) Payment of costs directly related to complying with
111 state and federal environmental statutes, rules, and regulations
112 governing school facilities.
113 (h) Payment of costs of leasing relocatable educational
114 facilities, of renting or leasing educational facilities and
115 sites pursuant to s. 1013.15(2), or of renting or leasing
116 buildings or space within existing buildings pursuant to s.
117 1013.15(4).
118 (i) Payment of the cost of school buses when a school
119 district contracts with a private entity to provide student
120 transportation services if the district meets the requirements
121 of this paragraph.
122 1. The district's contract must require that the private
123 entity purchase, lease-purchase, or lease, and operate and
124 maintain, one or more school buses of a specific type and size
125 that meet the requirements of s. 1006.25.
126 2. Each such school bus must be used for the daily
127 transportation of public school students in the manner required
128 by the school district.
129 3. Annual payment for each such school bus may not exceed
130 10 percent of the purchase price of the state pool bid.

131 4. The proposed expenditure of the funds for this purpose
132 must have been included in the district school board's notice of
133 proposed tax for school capital outlay as provided in s.
134 200.065(10).
135 (j) Payment of the cost of the opening day collection for
136 the library media center of a new school.
137
138 Section 2. Subsections (1) and (2) of section 1013.62,
139 Florida Statutes, are amended to read:
140 1013.62 Charter schools capital outlay funding.—
141 (1) In each year in which funds are appropriated for
142 charter school capital outlay purposes, the Commissioner of
143 Education shall allocate the funds among eligible charter
144 schools.
145 (a) To be eligible for a funding allocation, a charter
146 school must:
147 1.a. Have been in operation for 2 ~~3~~ or more years;
148 b. Have no more than two consecutive school grades lower
149 than "B" unless the school serves a student population at least
150 50 percent of which is eligible for free or reduced-price meals
151 under the National School Lunch Act ~~Be governed by a governing~~
152 ~~board established in the state for 3 or more years which~~
153 ~~operates both charter schools and conversion charter schools~~
154 ~~within the state~~;
155 c. Have an annual audit that does not reveal any of the
156 financial emergency conditions provided in s. 218.503(1) for the

157 most recent fiscal year for which such audit results are
158 available ~~Be an expanded feeder chain of a charter school within~~
159 ~~the same school district that is currently receiving charter~~
160 ~~school capital outlay funds~~;
161 d. Have received final approval from its sponsor pursuant
162 to s. 1002.33 for operation during that fiscal year; and
163 e. Serve students in facilities that are not provided by
164 the charter school's sponsor; or
165 ~~d. Have been accredited by the Commission on Schools of~~
166 ~~the Southern Association of Colleges and Schools; or~~
167 ~~e. Serve students in facilities that are provided by a~~
168 ~~business partner for a charter school in the workplace pursuant~~
169 ~~to s. 1002.33(15)(b).~~
170 2.a. Be part of a high-performing charter school system
171 pursuant to s. 1002.332; ~~Have financial stability for future~~
172 ~~operation as a charter school.~~
173 ~~3. Have satisfactory student achievement based on state~~
174 ~~accountability standards applicable to the charter school.~~
175 b.~~4.~~ Have received final approval from its sponsor
176 pursuant to s. 1002.33 for operation during that fiscal year;
177 and~~.~~
178 c.~~5.~~ Serve students in facilities that are not provided by
179 the charter school's sponsor.
180 ~~(b) The first priority for charter school capital outlay~~
181 ~~funding is to allocate to charter schools that received funding~~
182 ~~in the 2005-2006 fiscal year an allocation of the same amount~~

183 ~~per capital outlay full-time equivalent student, up to the~~
184 ~~lesser of the actual number of capital outlay full-time~~
185 ~~equivalent students in the current year, or the capital outlay~~
186 ~~full-time equivalent students in the 2005-2006 fiscal year.~~
187 ~~After calculating the first priority, the second priority is to~~
188 ~~allocate excess funds remaining in the appropriation in an~~
189 ~~amount equal to the per capital outlay full-time equivalent~~
190 ~~student amount in the first priority calculation to eligible~~
191 ~~charter schools not included in the first priority calculation~~
192 ~~and to schools in the first priority calculation with growth~~
193 ~~greater than the 2005-2006 capital outlay full-time equivalent~~
194 ~~students. After calculating the first and second priorities,~~
195 ~~excess funds remaining in the appropriation must be allocated to~~
196 ~~all eligible charter schools.~~
197 (b) ~~(c)~~ A charter school's allocation may not exceed one-
198 fortieth ~~one-fifteenth~~ of the cost per student station specified
199 in s. 1013.64(6)(b) or the amount of revenue per fixed capital
200 outlay full-time equivalent student generated by the school
201 district's levy of 1.5 mills pursuant to s. 1011.71(2),
202 whichever is less. Before releasing capital outlay funds to a
203 school district on behalf of the charter school, the Department
204 of Education must ensure that the district school board and the
205 charter school governing board enter into a written agreement
206 that provides for the reversion of any unencumbered funds and
207 all equipment and property purchased with public education funds
208 to the ownership of the district school board, as provided for

209 in subsection (3) if the school terminates operations. Any funds
210 recovered by the state shall be deposited in the General Revenue
211 Fund.
212 (c) ~~(d)~~ A charter school is not eligible for a funding
213 allocation if it was created by the conversion of a public
214 school and operates in facilities provided by the charter
215 school's sponsor for a nominal fee, or at no charge, or if it is
216 directly or indirectly operated by the school district.
217 (d) ~~(e)~~ Unless otherwise provided in the General
218 Appropriations Act, the state funding allocation for each
219 eligible charter school shall be ~~is~~ determined by multiplying
220 the school's projected student enrollment by one-fortieth ~~one-~~
221 ~~fifteenth~~ of the cost-per-student station specified in s.
222 1013.64(6)(b) for an elementary, middle, or high school, as
223 appropriate. If the funds appropriated are not sufficient, the
224 charter school shall receive funding to achieve one-fortieth of
225 the cost per student station or the amount of revenue per fixed
226 capital outlay full-time equivalent student generated by the
227 school district's levy of 1.5 mills pursuant to s. 1011.71(2),
228 whichever is less, from the revenues generated by the school
229 district levy of ad valorem property taxes ~~the commissioner~~
230 ~~shall prorate the available funds among eligible charter~~
231 ~~schools~~. ~~However,~~ A charter school or charter lab school may not
232 receive state charter school capital outlay funds or local ad
233 valorem capital outlay funds greater than the one-fortieth ~~one-~~
234 ~~fifteenth~~ cost per student station formula if the charter

235 school's combination of state charter school capital outlay
236 funds, capital outlay funds calculated through the reduction in
237 the administrative fee provided in s. 1002.33(20), and capital
238 outlay funds allowed in s. 1002.32(9)(e) and (h) exceeds the
239 one-fortieth ~~one-fifteenth~~ cost per student station formula.
240 (e) ~~(f)~~ Funds shall be distributed on the basis of the
241 capital outlay full-time equivalent membership by grade level,
242 which is calculated by averaging the results of the second and
243 third enrollment surveys. The Department of Education shall
244 distribute capital outlay funds monthly, beginning in the first
245 quarter of the fiscal year, based on one-twelfth of the amount
246 the department reasonably expects the charter school to receive
247 during that fiscal year. The commissioner shall adjust
248 subsequent distributions as necessary to reflect each charter
249 school's actual student enrollment as reflected in the second
250 and third enrollment surveys. The commissioner shall establish
251 the intervals and procedures for determining the projected and
252 actual student enrollment of eligible charter schools.
253 (2) A charter school's governing body may use charter
254 school capital outlay funds received pursuant to this section
255 and s. 1011.71(2) for the following purposes:
256 (a) Purchase of real property.
257 (b) Construction of school facilities.
258 (c) Purchase, lease-purchase, or lease of permanent or
259 relocatable school facilities.
260 (d) Purchase of vehicles to transport students to and from

261 the charter school.
262 (e) Renovation, repair, and maintenance of school
263 facilities that the charter school owns or is purchasing through
264 a lease-purchase or long-term lease of 5 years or longer.
265 ~~(f) Effective July 1, 2008, purchase, lease-purchase, or~~
266 ~~lease of new and replacement equipment, and enterprise resource~~
267 ~~software applications that are classified as capital assets in~~
268 ~~accordance with definitions of the Governmental Accounting~~
269 ~~Standards Board, have a useful life of at least 5 years, and are~~
270 ~~used to support schoolwide administration or state mandated~~
271 ~~reporting requirements.~~
272 (f) ~~(g)~~ Payment of the cost of premiums for property and
273 casualty insurance necessary to insure the school facilities.
274 (g) ~~(h)~~ Purchase, lease-purchase, or lease of driver's
275 education vehicles; motor vehicles used for the maintenance or
276 operation of plants and equipment; security vehicles; or
277 vehicles used in storing or distributing materials and
278 equipment.
279 (h) Purchase, lease-purchase, or lease of new and
280 replacement equipment; computer hardware, including electronic
281 hardware and other hardware devices necessary for gaining access
282 to or enhancing the use of electronic content and resources or
283 to facilitate the access to and the use of a charter school's
284 digital classrooms plan pursuant to s. 1011.62, excluding
285 software other than the operating system necessary to operate
286 the hardware or device; and enterprise resource software

287 applications that are classified as capital assets in accordance
288 with definitions of the Governmental Accounting Standards Board,
289 have a useful life of at least 5 years, and are used to support
290 schoolwide administration or state-mandated reporting
291 requirements. Enterprise resource software may be acquired by
292 annual license fees, maintenance fees, or lease agreement.
293 (i) Payment of the cost of the opening day collection for
294 the library media center of a new school.
295
296 Conversion charter schools may use capital outlay funds received
297 through the reduction in the administrative fee provided in s.
298 1002.33(20) for renovation, repair, and maintenance of school
299 facilities that are owned by the sponsor.
300 Section 3. Paragraphs (a) and (b) of subsection (2) and
301 paragraphs (b), (c), (d), and (e) of subsection (6) of section
302 1013.64, Florida Statutes, are amended to read:
303 1013.64 Funds for comprehensive educational plant needs;
304 construction cost maximums for school district capital
305 projects.—Allocations from the Public Education Capital Outlay
306 and Debt Service Trust Fund to the various boards for capital
307 outlay projects shall be determined as follows:
308 (2)(a) The department shall establish, as a part of the
309 Public Education Capital Outlay and Debt Service Trust Fund, a
310 separate account, in an amount determined by the Legislature, to
311 be known as the "Special Facility Construction Account." The
312 Special Facility Construction Account shall be used to provide

313 necessary construction funds to school districts which have
314 urgent construction needs but which lack sufficient resources at
315 present, and cannot reasonably anticipate sufficient resources
316 within the period of the next 3 years, for these purposes from
317 currently authorized sources of capital outlay revenue. A school
318 district requesting funding from the Special Facility
319 Construction Account shall submit one specific construction
320 project, not to exceed one complete educational plant, to the
321 Special Facility Construction Committee. A ~~No~~ district may not
322 ~~shall~~ receive funding for more than one approved project in any
323 3-year period or while any portion of the district's
324 participation requirement remains outstanding. The first year of
325 the 3-year period shall be the first year a district receives an
326 appropriation. The department shall encourage a construction
327 program that reduces the average size of schools in the
328 district. The request must meet the following criteria to be
329 considered by the committee:
330 1. The project must be deemed a critical need and must be
331 recommended for funding by the Special Facility Construction
332 Committee. Before ~~Prior to~~ developing construction plans for the
333 proposed facility, the district school board must request a
334 preapplication review by the Special Facility Construction
335 Committee or a project review subcommittee convened by the chair
336 of the committee to include two representatives of the
337 department and two staff members from school districts not
338 eligible to participate in the program. The request for a

339 preapplication review may be made at any time; however, for
340 inclusion in the Department of Education's next annual capital
341 outlay legislative budget request, the request for a
342 preapplication review must be made before February 1 of the
343 fiscal year before the legislative budget request. Within 90 ~~60~~
344 days after receiving the preapplication review request, the
345 committee or subcommittee must meet in the school district to
346 review the project proposal and existing facilities. To
347 determine whether the proposed project is a critical need, the
348 committee or subcommittee shall consider, at a minimum, the
349 capacity of all existing facilities within the district as
350 determined by the Florida Inventory of School Houses; the
351 district's pattern of student growth; the district's existing
352 and projected capital outlay full-time equivalent student
353 enrollment as determined by the demographic, revenue, and
354 education estimating conferences established in s. 216.136
355 ~~department~~; the district's existing satisfactory student
356 stations; the use of all existing district property and
357 facilities; grade level configurations; and any other
358 information that may affect the need for the proposed project.
359 2. The construction project must be recommended in the
360 most recent survey or survey amendment cooperatively prepared
361 ~~surveys~~ by the district and the department, and approved by the
362 department under the rules of the State Board of Education. If a
363 district employs a consultant in the preparation of a survey or
364 survey amendment, the consultant may not be employed by or

365 receive compensation from a third party that designs or
366 constructs a project recommended by the survey.
367 3. The construction project must appear on the district's
368 approved project priority list under the rules of the State
369 Board of Education.
370 4. The district must have selected and had approved a site
371 for the construction project in compliance with s. 1013.36 and
372 the rules of the State Board of Education.
373 5. The district shall have developed a district school
374 board adopted list of facilities that do not exceed the norm for
375 net square feet occupancy requirements under the State
376 Requirements for Educational Facilities, using all possible
377 programmatic combinations for multiple use of space to obtain
378 maximum daily use of all spaces within the facility under
379 consideration.
380 6. Upon construction, the total cost per student station,
381 including change orders, may ~~must~~ not exceed the cost per
382 student station as provided in subsection (6), except for cost
383 overruns created by a disaster as defined in s. 252.34 or an
384 unforeseeable circumstance beyond the district's control as
385 determined by the Special Facility Construction Committee.
386 7. There shall be an agreement signed by the district
387 school board stating that it will advertise for bids within 30
388 days of receipt of its encumbrance authorization from the
389 department.
390 8. For construction projects for which Special Facility

391 Construction Account funding is sought before the 2019-2020
392 fiscal year, the district shall, at the time of the request and
393 for a continuing period necessary to meet the district's
394 participation requirement under subparagraph 11. ~~of 3 years~~,
395 levy the maximum millage against their nonexempt assessed
396 property value as allowed in s. 1011.71(2) or shall raise an
397 equivalent amount of revenue from the school capital outlay
398 surtax authorized under s. 212.055(6). Beginning with the 2019-
399 2020 fiscal year, for construction projects for which Special
400 Facility Construction Account funding is sought, the district
401 shall, for a minimum of 3 years before the request and for a
402 continuing period necessary to meet the district's participation
403 requirement under subparagraph 11., levy the maximum millage
404 against their nonexempt assessed property value as allowed in s.
405 1011.71(2) or raise an equivalent amount of revenue from the
406 school capital outlay surtax authorized under s. 212.055(6). Any
407 district with a new or active project, funded under the
408 provisions of this subsection, shall be required to budget no
409 more than the value of 1.0 mill ~~1.5 mills~~ per year to the
410 project until the district's ~~to satisfy the annual~~ participation
411 requirement relating to the local discretionary capital
412 improvement millage authorized under s. 1011.71(2) or the
413 equivalent amount of revenue from the school capital outlay
414 surtax authorized under s. 212.055(6) is satisfied ~~in the~~
415 ~~Special Facility Construction Account~~.
416 9. If a contract has not been signed 90 days after the

417 advertising of bids, the funding for the specific project shall
418 revert to the Special Facility New Construction Account to be
419 reallocated to other projects on the list. However, an
420 additional 90 days may be granted by the commissioner.
421 10. The department shall certify the inability of the
422 district to fund the survey-recommended project over a
423 continuous 3-year period using projected capital outlay revenue
424 derived from s. 9(d), Art. XII of the State Constitution, as
425 amended, paragraph (3)(a) of this section, and s. 1011.71(2).
426 11. The district shall have on file with the department an
427 adopted resolution acknowledging its ~~3-year~~ commitment to
428 satisfy its participation requirement. The district's
429 participation requirement is equivalent to ~~of~~ all unencumbered
430 and future revenue acquired in the year of the initial
431 appropriation and for the 2 years immediately following the
432 initial appropriation from s. 9(d), Art. XII of the State
433 Constitution, as amended, paragraph (3)(a) of this section, and
434 s. 1011.71(2).
435 12. Final phase III plans must be certified by the
436 district school board as complete and in compliance with the
437 building and life safety codes before June 1 of the year the
438 application is made ~~prior to August 1~~.
439 (b) The Special Facility Construction Committee shall be
440 composed of the following: two representatives of the Department
441 of Education, a representative from the Governor's office, a
442 representative selected annually by the district school boards,

443 and a representative selected annually by the superintendents. A
444 representative of the department shall chair the committee.
445 (6)
446 (b)1. A district school board may ~~must~~ not use funds from
447 the following sources: Public Education Capital Outlay and Debt
448 Service Trust Fund; School District and Community College
449 District Capital Outlay and Debt Service Trust Fund; Classrooms
450 First Program funds provided in s. 1013.68; nonvoted 1.5-mill
451 levy of ad valorem property taxes provided in s. 1011.71(2);
452 Classrooms for Kids Program funds provided in s. 1013.735;
453 District Effort Recognition Program funds provided in s.
454 1013.736; and ~~or~~ High Growth District Capital Outlay Assistance
455 Grant Program funds provided in s. 1013.738 for any new
456 construction of educational plant space with a total cost per
457 student station, including change orders, that equals more than:
458 a. $17,952 for an elementary school,
459 b. $19,386 for a middle school, or
460 c. $25,181 for a high school,
461
462 (January 2006) as adjusted annually to reflect increases or
463 decreases in the Consumer Price Index.
464 2. Effective July 1, 2017, in addition to the funding
465 sources listed in subparagraph 1., a district school board may
466 not use funds from the following sources: nonvoted 1.5-mill levy
467 of ad valorem property taxes provided in s. 1011.71(3); proceeds
468 received through the provisions of s. 1011.73 and s. 9, Art. VII

469 of the State Constitution; funds provided by school district
470 bonds; sales surtax funds authorized in s. 212.055; impact fees
471 authorized in s. 163.31801; and funds received pursuant to s.
472 212.20(6)(d)6.a., for any new construction of educational plant
473 space with a total cost per student station, including change
474 orders, that equals more than the current adjusted amounts
475 provided in sub-subparagraphs 1.a.-c., which shall subsequently
476 be adjusted annually to reflect increases or decreases in the
477 Consumer Price Index.
478 3. A district school board may ~~must~~ not use funds from the
479 Public Education Capital Outlay and Debt Service Trust Fund or
480 the School District and Community College District Capital
481 Outlay and Debt Service Trust Fund for any new construction of
482 an ancillary plant that exceeds 70 percent of the average cost
483 per square foot of new construction for all schools.
484 (c)1. Except as otherwise provided, new construction
485 initiated by a district school board may ~~after June 30, 1997,~~
486 ~~must~~ not exceed the cost per student station as provided in
487 paragraph (b).
488 2. New construction initiated by a district school board
489 on or after July 1, 2017, may not exceed the cost per student
490 station provided in paragraph (b). A district that exceeds the
491 cost per student station provided in paragraph (b) is ineligible
492 for allocations from the Public Capital Outlay and Debt Service
493 Trust Fund for the next 3 years in which the district would have
494 received allocations had the violation not occurred.

495 (d) The department shall:
496 1. Compute for each calendar year the statewide average
497 construction costs for facilities serving each instructional
498 level, for relocatable educational facilities, for
499 administrative facilities, and for other ancillary and auxiliary
500 facilities. The department shall compute the statewide average
501 costs per student station for each instructional level.
502 2. Annually review the actual completed construction costs
503 of educational facilities in each school district. For any
504 school district in which the total actual cost per student
505 station, including change orders, exceeds the statewide limits
506 established in paragraph (b), the school district shall report
507 to the department the actual cost per student station and the
508 reason for the school district's inability to adhere to the
509 limits established in paragraph (b). The department shall
510 collect all such reports and shall report to the Governor, the
511 President of the Senate, and the Speaker of the House of
512 Representatives by December 31 of each year a summary of each
513 school district's spending in excess of the cost per student
514 station provided in paragraph (b) as reported by the school
515 districts.
516
517 Cost per student station includes contract costs, legal and
518 administrative costs, fees of architects and engineers,
519 furniture and equipment, site costs, ~~and~~ site improvement costs,
520 and offsite improvement costs. Cost per student station does not

521 include the cost of purchasing or leasing the site for the
522 construction or the cost of related offsite improvements.
523 (e) The department shall conduct a study, in consultation
524 with the Office of Economic and Demographic Research, of the
525 total cost per student station amounts under paragraph (b) using
526 the most recent available information. The department shall
527 report the final results of the analysis to the Governor, the
528 President of the Senate, and the Speaker of the House of
529 Representatives by March 1, 2017 ~~The restrictions of this~~
530 ~~subsection on the cost per student station of new construction~~
531 ~~do not apply to a project funded entirely from proceeds received~~
532 ~~by districts through provisions of ss. 212.055 and 1011.73 and~~
533 ~~s. 9, Art. VII of the State Constitution, if the school board~~
534 ~~approves the project by majority vote~~.
535 Section 4. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N	Yaffe	Luczynski
2) Appropriations Committee		Keith	Leznoff
3) Health & Human Services Committee			

SUMMARY ANALYSIS

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

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

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

The bill has an insignificant fiscal impact to state government revenues and expenditures. In addition, the bill has an indeterminate fiscal impact to local government and the private sector.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

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

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

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

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

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

Effect of Proposed Changes

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

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

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

The bill removes the requirements that the Office of the State Fire Marshal provide training and education to the employees of the AHCA and local government inspectors. This training has not been conducted in at least five years[7], and does not presently occur.[8]

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

B. SECTION DIRECTORY:

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

Section 2: provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Insignificant: See Fiscal Comments.

2. Expenditures:

   Insignificant: See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Indeterminate: See Fiscal Comments.

2. Expenditures:

   Indeterminate: See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that an ALF facility could potentially need upgrades to comply with the updated Life Safety Code specified in the bill, there could be additional expenditures for an ALF. However, as a result of the bill ALF's will be able to build and add improvements to new and existing structures in accordance with the updated Life Safety Code in order to utilize modern advancements in safety, technology, materials, and building design.

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[6] The Department of Financial Services, Agency Analysis of 2015 House Bill 965, p. 2 (Dec. 22, 2015).
[7] Email correspondence with The Department of Financial Services (Feb. 8, 2016), RE: House Bill 965 Inquiry.
[8] Email from Susan E. Anderson, Vice President of Public Policy, Florida Assisted Living Federation of America, RE: HB Florida Insurance & Banking Subcommittee -- House Bill 965 Inquiry (Jan. 29, 2016).

D. FISCAL COMMENTS:

Under current law, the Office of the State Fire Marshal (OSFM), within existing budget, is required to provide training and education on the application of the Life Safety Code to the AHCA, local government inspectors, and other ALF provider associations. The bill removes the training and education requirement of the OSFM. The OSFM currently has no staffing resources specifically identified for the training requirements under current law; therefore, the bill will have minimal impact to workload performed by the OSFM. According to the DFS, the OSFM has not conducted this training in the past five years.[9]

In addition, to the extent that the AHCA and local government inspectors will no longer have to organize staff time related to training and education on the Life Safety Code provided through the OSFM, there is the potential for a decrease in workload moving forward.

As is currently required of a local government, the bill also requires a utility to not charge a fee in excess of the actual expense of installing and maintaining automatic fire sprinkler systems in existing and properly licensed ALF's. To that extent, there could potentially be a negative, yet indeterminate revenue impact to a utility if they were currently overcharging for those services.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

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

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

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

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

[9] Email correspondence with The Department of Financial Services (Feb. 8, 2016), RE: House Bill 965 Inquiry.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Appropriations Committee
2 Representative Harrison offered the following:
3
4 **Amendment (with title amendment)**
5 Remove lines 25-26 and insert:
6 facility. Uniform firesafety standards for assisted living
7 facilities shall be established by the State Fire Marshal
8 pursuant to s.
9 Between lines 225 and 226, insert:
10 d. An assisted living facility licensed before July 1,
11 2016, is exempt from any requirement in the uniform firesafety
12 code established and adopted pursuant to s. 633.206 by the State
13 Fire Marshal for assisted living facilities which exceeds the
14 firesafety requirements of NFPA 101, 1994 edition, Chapter 23,
15 Existing Residential Board and Care Occupancies. However, a
16 facility that undergoes building rehabilitation as described by
17 the uniform firesafety code established by the State Fire

18 Marshal must thereafter be in compliance with the uniform
19 firesafety code in effect for assisted living facilities under
20 sub-subparagrah a.
21
22 ----------
23 **T I T L E A M E N D M E N T**
24 Remove line 8 and insert:
25 assisted living facilities; providing an exemption for
26 existing assisted living facilities under certain
27 conditions; providing an effective

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 989 Implementation of Water and Land Conservation Constitutional Amendment
SPONSOR(S): Harrell, Caldwell and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1168

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Agriculture & Natural Resources Appropriations Subcommittee	13 Y, 0 N	Massengale	Massengale
2) Appropriations Committee		Massengale SM	Leznoff

SUMMARY ANALYSIS

In 2014, the voters of the state of Florida approved an amendment to the Florida Constitution to create Article X, Section 28, which requires that 33 percent of documentary stamp taxes collected be deposited into the Land Acquisition Trust Fund (LATF) and prohibits funds from the LATF from being used for a purpose not specified in the constitution. In 2015, chapter 2015-229, Laws of Florida, became law and amended the relevant statutes to comply with this constitutional requirement. The bill amended section 375.041, F.S., related to the Land Acquisition Trust Fund to require that funds be used for certain debt service obligations and to require that $32 million be distributed to the South Florida Water Management District for the Long-Term Plan. The section further provides that any remaining moneys in the Land Acquisition Trust Fund that are not distributed as provided above may be appropriated from time to time for the purposes set forth in s. 28, Art. X of the State Constitution.

HB 989 amends s. 375.041, F.S. to provide for the distribution of funds deposited into the Land Acquisition Trust Fund. Of the funds remaining after the payment of certain debt service obligations, the Legislature will be required to appropriate a minimum of the lesser of 25 percent or $200 million for Everglades projects that implement the Comprehensive Everglades Restoration Plan (CERP), including the Central Everglades Planning Project subject to congressional authorization, the Long-Term Plan, and the Northern Everglades and Estuaries Protection Program.

The bill requires that from these funds, $32 million will be distributed each fiscal year through the 2023-2024 fiscal year to the South Florida Water Management District (SFWMD) for the Long-Term Plan. After deducting the $32 million, from the funds remaining, a minimum of the lesser of 76.5 percent or $100 million will be appropriated each fiscal year through the 2025-2026 fiscal year for the planning, design, engineering and construction of the CERP.

The bill requires the Department of Environmental Protection (DEP) and the SFWMD to give preference to projects that reduce harmful discharges from Lake Okeechobee to the St. Lucie or Caloosahatchee estuaries in a timely manner.

The House proposed Fiscal Year 2016-2017 General Appropriations Act provides $32 million for the Long-Term Plan, $100 million for the CERP and $66 million for the Northern Everglades and Estuaries Protection Program.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

On November 4, 2014, Florida voters approved an initiative petition relating to water and land conservation. The provision added a section 28 to Article X of the Florida Constitution:

SECTION 28. Land Acquisition Trust Fund.—

a) Effective on July 1 of the year following passage of this amendment by the voters, and for a period of 20 years after that effective date, the Land Acquisition Trust Fund shall receive no less than 33 percent of net revenues derived from the existing excise tax on documents[1], as defined in the statutes in effect on January 1, 2012, as amended from time to time, or any successor or replacement tax, after the Department of Revenue first deducts a service charge to pay the costs of the collection and enforcement of the excise tax on documents.

b) Funds in the Land Acquisition Trust Fund shall be expended only for the following purposes:

1) As provided by law, to finance or refinance: the acquisition and improvement of land, water areas, and related property interests, including conservation easements, and resources for conservation lands including wetlands, forests, and fish and wildlife habitat; wildlife management areas; lands that protect water resources and drinking water sources, including lands protecting the water quality and quantity of rivers, lakes, streams, springsheds, and lands providing recharge for groundwater and aquifer systems; lands in the Everglades Agricultural Area and the Everglades Protection Area, as defined in Article II, Section 7(b); beaches and shores; outdoor recreation lands, including recreational trails, parks, and urban open space; rural landscapes; working farms and ranches; historic or geologic sites; together with management, restoration of natural systems, and the enhancement of public access or recreational enjoyment of conservation lands.

2) To pay the debt service on bonds issued pursuant to Article VII, Section 11(e). c) The moneys deposited into the Land Acquisition Trust Fund, as defined by the statutes in effect on January 1, 2012, shall not be or become commingled with the General Revenue Fund of the state.

As a result of Special Session A in 2015, chapter 2015-229, Laws of Florida, became law and amended the relevant statutes to comply with this constitutional requirement. As part of chapter 2015-229, L.O.F., s. 375.041, F.S. was amended to require moneys from the Land Acquisition Trust Fund to be allocated as follows:

1. First, to pay debt service or to fund debt service reserve funds, rebate obligations, or other amounts payable with respect to Florida Forever bonds issued under s. 215.618; and pay debt service, provide reserves, and pay rebate obligations and other amounts due with respect to Everglades restoration bonds issued under s. 215.619;

2. Then, to pay the debt service on bonds issued before February 1, 2009, by the South Florida Water Management District and the St. Johns River Water Management District, which are secured by revenues provided pursuant to former s. 373.59, Florida Statutes 2014, or which are necessary to fund debt service reserve funds, rebate obligations, or other amounts payable with respect to such bonds. This paragraph expires July 1, 2016; and

[1] The documentary stamp tax is imposed on documents that transfer interest in Florida real property and certain types of debt. Documents subject to the tax include deeds, bonds, corporate shares, notes and written obligations to pay money, and mortgages, lines and other evidences of indebtedness. ss. ss. 201.02, 201.07 and 201.208, F.S.

3. Then, to distribute $32 million each fiscal year to the South Florida Water Management District for the Long-Term Plan as defined in s. 373.4592(2). This paragraph expires July 1, 2024.

The section further provides that any remaining moneys in the Land Acquisition Trust Fund that are not distributed as provided above may be appropriated from time to time for the purposes set forth in s. 28, Art. X of the State Constitution.

Comprehensive Everglades Restoration Plan
The Comprehensive Everglades Restoration Program (CERP) is a large, comprehensive, long-term 50-50 partnership with the federal government to restore the Everglades. The plan originally approved in the 2000 federal Water Resources Development Act includes more than 60 projects that will take more than 30 years to complete and will cost an estimated $13.5 billion.[2] The program works in conjunction with other state and federal efforts to revitalize wetlands, lakes, bays and estuaries across south Florida's ecosystem, for the purpose of improving the Everglades and ensuring the area's water supply can meet future needs. DEP and the South Florida Water Management District work in collaboration to review each program proposal, with DEP having final approval authority. Projects must receive DEP approval before being submitted to Congress or the Legislature for funding.

The Central Everglades Planning Project
The Central Everglades Planning Project (CEPP) is a suite of projects in the central Everglades intended to allow more water to be directed south to the central Everglades, Everglades National Park, and Florida Bay. On December 23, 2014, the U.S. Army Corps of Engineers Chief of Engineers submitted his Project Implementation Report for CEPP to the Secretary of the Army for transmission to Congress for congressional authorization. The proposed CEPP is comprised of increments of six components of CERP, including the Everglades Agricultural Area (EAA) Storage Reservoir - Phase I, which was conditionally authorized by Section 601 (b)(2)(C)(ii) of WRDA 2000. However, the reporting officers recommended new authorization consistent with Section 601 (d) of WRDA 2000 due to changes in scope and the inclusion of additional CERP components. The reporting officers recommended increments of the following six components of CERP to be integrated with the existing facilities of the C&SF system: Everglades Agricultural Area Storage Reservoirs (Component G); Water Conservation Area (WCA)-3 Decompartmentalization and Sheetflow Enhancement (Components AA and QQ); S-356 Pump Station Modifications (Component FF); L-31 N Improvements for Seepage Management (Component V); System-wide Operational Changes - Everglades Rain-Driven Operations (Component H); and Flow to Northwest and Central.WCA-3A (Component II).[3]

Long-Term Plan
Section 373.4592(2), F.S. references the "Long-Term Plan" relating to Everglades protection. The Long-Term Plan resulted from the 1994 Everglades Forever Act, which requires the SFWMD to submit a water quality plan to DEP. The Plan's overarching purpose is to ensure all water entering the Everglades Protection Area complies with state and federal water quality standards. The plan calls for enhancements to existing storm water treatment areas, expanded best management practices and integration with CERP projects.[4] In 2012, the DEP and the SFWMD, in consultation with U.S. Environmental Protection Agency, developed a technical plan to meet water quality standards, which includes additional stormwater treatment areas and storage reservoirs at a cost of $880 million over a 13-year period. A total of $500.7 million in funds will be provided by the South Florida Water Management District with the balance to be provided by the state. The 2013 Legislature appropriated $32 million on a recurring basis to support the implementation of the technical water quality plan.[5]

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[2] http://www.dep.state.fl.us/secretary/everglades/ (last visited 1/19/2015).
[3] U.S, Army Corps of Engineers CEPP Project Implementation Report, available at: http://www.saj.usace.army.mil/Portals/44/docs/Environmental/CEPP/CentralEverglades-Dec2014%20Chief's%20Report.pdf (last accessed 1/27/2016).
[4] South Florida Water Management District, available at: http://my.sfwmd.gov/portal/page/portal/xweb%20protecting%20and%20restoring/water%20quality%20stormwater%20treatment%20areas (last accessed 1/13/2016).
[5] http://edr.state.fl.us/Content/long-range-financial-outlook/3-Year-Plan_Fall-2015_1617-1819.pdf

Northern Everglades and Estuaries Protection Program (NEEPP)
The term "Northern Everglades" refers to the Lake Okeechobee watershed, the Caloosahatchee River watershed, and the St. Lucie River watershed.[6] The Northern Everglades and Estuaries Protection Program (NEEPP) promotes a comprehensive, interconnected watershed approach to protect Lake Okeechobee and the Caloosahatchee and St. Lucie River watersheds. It includes the Lake Okeechobee Watershed Protection Program and the Caloosahatchee and St. Lucie Watershed Protection Program. The 2016 Legislature enacted legislation, Chapter 2016-1, L.O.F., updating and restructuring NEEPP to reflect and build upon the DEP's completion of basin management action plans (BMAPs) for Lake Okeechobee, the Caloosahatchee River and Estuary, and the St. Lucie River and Estuary, and the Department of Agriculture and Consumer Services' (DACS) implementation of best management practices (BMPs.[7]

Provisions of Bill
The bill amends s. 375.041, F.S. to provide for distribution of funds from the Land Acquisition Trust Fund. The bill retains the requirement that funds first be distributed to pay debt service or to fund debt service reserve funds, rebate obligations, or other amounts payable with respect to Florida Forever bonds issued under s. 215.618, F.S., and Everglades restoration bonds issued under s. 215.619, F.S.

Of the funds remaining after this debt service distribution, the Legislature will be required to appropriate a minimum of the lesser of 25 percent or $200 million for Everglades projects that implement:
1. the Comprehensive Everglades Restoration Plan (CERP) as set forth in s. 373.470, including the Central Everglades Planning Project subject to congressional authorization;
2. the Long-Term Plan as defined in s. 373.4592(2); and
3. the Northern Everglades and Estuaries Protection Program as set forth in s. 373.4595.

From these funds, $32 million will be distributed each fiscal year through the 2023-2024 fiscal year to the South Florida Water Management District for the Long-Term Plan. After deducting the $32 million, from the funds remaining, a minimum of the lesser of 76.5 percent or $100 million will be appropriated each fiscal year through the 2025-2026 fiscal year for the planning, design, engineering and construction of the CERP.

The bill requires DEP and the SFWMD to give preference to projects that reduce harmful discharges from Lake Okeechobee to the St. Lucie or Caloosahatchee estuaries in a timely manner.

Finally, the bill repeals the provision, which expires July 1, 2016, paying for the SFWMD's and the St. Johns River Water Management District's debt service on bonds issued before February 1, 2009.

B. SECTION DIRECTORY:

Section 1: Amends s. 375.041, F.S. relating to the Land Acquisition Trust Fund.

Section 2: Provides effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

[6] s. 373.4595(2)(l)
[7] Florida Senate Bill Analysis, CS/CS/SB 552

The bill specifies how the Land Acquisition Trust Fund would be distributed for Everglades restoration. See the table below.

(In millions)

State Fiscal Year	33% LATF	Less Debt Service	Lesser of 25% or $200M for Everglades	Long-Term Plan	CERP (Lesser of 76.5% or $100M)	Remaining Everglades Funds
2016-17	$823.8	$171.3	$163.1	$32.0	$100.0	$31.1
2017-18	$879.6	$171.4	$177.1	$32.0	$100.0	$45.1
2018-19	$922.9	$171.5	$187.9	$32.0	$100.0	$55.9
2019-20	$957.4	$171.6	$196.4	$32.0	$100.0	$64.4
2020-21	$992.4	$171.6	$200.00	$32.0	$100.0	$68.0
2021-22	$1,026.1	$150.2	$200.00	$32.0	$100.0	$68.0
2022-23	$1,064.7	$139.3	$200.00	$32.0	$100.0	$68.0
2023-24	$1,105.6	$119.2	$200.00	$32.0	$100.0	$68.0
2024-25	$1,149.6	$119.2	$200.00		$100.0	$100.0
2025-26	$1,194.9	$93.8	$200.00		$100.0	$100.0

The House proposed Fiscal Year 2016-2017 General Appropriations Act provides $32 million for the Long-Term Plan, $100 million for the CERP and $66 million for the Northern Everglades and Estuaries Protection Program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to implementation of the water and
3 land conservation constitutional amendment; amending
4 s. 375.041, F.S.; requiring a minimum specified
5 percentage of funds within the Land Acquisition Trust
6 Fund to be appropriated for Everglades restoration
7 projects; providing a preference in the use of funds
8 to certain projects that reduce discharges to the St.
9 Lucie and Caloosahatchee estuaries; providing an
10 effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Subsection (3) of section 375.041, Florida
15 Statutes, is amended to read:
16 375.041 Land Acquisition Trust Fund.—
17 (3) Funds distributed into the Land Acquisition Trust Fund
18 pursuant to s. 201.15 shall be applied:
19 (a) First, to pay debt service or to fund debt service
20 reserve funds, rebate obligations, or other amounts payable with
21 respect to Florida Forever bonds issued under s. 215.618; and
22 pay debt service, provide reserves, and pay rebate obligations
23 and other amounts due with respect to Everglades restoration
24 bonds issued under s. 215.619; <u>and</u>
25 (b) <u>Of the funds remaining after the payments required</u>
26 <u>under paragraph (a) but before funds may be appropriated or</u>

27 dedicated for other uses, a minimum of the lesser of 25 percent
28 or $200 million shall be appropriated annually for Everglades
29 projects that implement the Comprehensive Everglades Restoration
30 Plan as set forth in s. 373.470, including the Central
31 Everglades Planning Project subject to congressional
32 authorization; the Long-Term Plan as defined in s. 373.4592(2);
33 and the Northern Everglades and Estuaries Protection Program as
34 set forth in s. 373.4595. From these funds, $32 million shall be
35 distributed each fiscal year through the 2023-2024 fiscal year
36 to the South Florida Water Management District for the Long-Term
37 Plan as defined in s. 373.4592(2). After deducting the $32
38 million distributed under this paragraph, from the funds
39 remaining, a minimum of the lesser of 76.5 percent or $100
40 million shall be appropriated each fiscal year through the 2025-
41 2026 fiscal year for the planning, design, engineering, and
42 construction of the Comprehensive Everglades Restoration Plan as
43 set forth in s. 373.470, including the Central Everglades
44 Planning Project subject to congressional authorization. The
45 Department of Environmental Protection and the South Florida
46 Water Management District shall give preference to those
47 Everglades restoration projects that reduce harmful discharges
48 of water from Lake Okeechobee to the St. Lucie or Caloosahatchee
49 estuaries in a timely manner ~~Then, to pay the debt service on~~
50 ~~bonds issued before February 1, 2009, by the South Florida Water~~
51 ~~Management District and the St. Johns River Water Management~~
52 ~~District, which are secured by revenues provided pursuant to~~

53 ~~former s. 373.59, Florida Statutes 2014, or which are necessary~~
54 ~~to fund debt service reserve funds, rebate obligations, or other~~
55 ~~amounts payable with respect to such bonds. This paragraph~~
56 ~~expires July 1, 2016; and~~
57 ~~(c) Then, to distribute $32 million each fiscal year to~~
58 ~~the South Florida Water Management District for the Long-Term~~
59 ~~Plan as defined in s. 373.4592(2). This paragraph expires July~~
60 ~~1, 2024~~.
61 Section 2. This act shall take effect July 1, 2016.

HB 1169

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1169 Emergency Management
SPONSOR(S): Powell
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1288

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Economic Development & Tourism Subcommittee	13 Y, 0 N	Hancock	Duncan
2) Appropriations Committee		Delaney	Leznoff
3) Economic Affairs Committee			

SUMMARY ANALYSIS

The Division of Emergency Management (DEM), located within the Executive Office of the Governor, is responsible for administering programs to rapidly apply all available aid to communities stricken by an emergency and preparing a state comprehensive emergency management plan (CEMP). The CEMP is integrated into and coordinated with the federal government's emergency management plans. Both the state and federal government have established processes to prepare for, respond to, recover from, and mitigate natural, technological, or manmade disasters.

Although Florida's CEMP establishes three levels of activation for the SERT to effectively monitor and respond to threats or emergency situations, the term "activate" is not defined in statute. The bill clarifies the process utilized by DEM's State Emergency Response Team (SERT) to effectively mobilize resources and conduct activities to guide and support local emergency management efforts.

The bill clarifies the definition of the term "activate" as "the execution and implementation of the necessary plans and activities required to mitigate, respond to, or recover from a potential or actual state of emergency or disaster declared pursuant to this chapter and the state comprehensive emergency management plan which specifies levels of activation,"

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

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation:

State Emergency Management Act

The State Emergency Management Act[1] created the Florida Division of Emergency Management (DEM), conferred emergency powers upon the Governor, and provided for the rendering of mutual aid among political subdivisions of the state, other states, and with the Federal Government.[2] It was enacted with a declaration of state policy "that all emergency management functions of the state be coordinated to the maximum extent with comparable functions of the Federal Government... to the end that the most effective preparation and use may be made of the workforce, resources, and facilities of the nation for dealing with any emergency that may occur."[3]

Florida Division of Emergency Management's Comprehensive Emergency Management Plan

DEM is tasked with administering programs to rapidly apply all available aid to communities stricken by an emergency.[4] In order to do so, DEM is responsible for preparing a state comprehensive emergency management plan (CEMP), "which shall be integrated into and coordinated with the emergency management plans and programs of the Federal Government."[5] The CEMP serves as the framework for disaster and emergency preparedness, response, recovery and mitigation activities.[6]

Florida Emergency Process

When an imminent or actual event threatens the state, the Director of DEM activates the State Emergency Response Team (SERT) and recommends that the Governor declare a state of emergency.[7] The SERT provides management of response and recovery activities from the State Emergency Operations Center (SEOC), a permanent facility located in Tallahassee.[8] The SEOC operates 24 hours a day, 7 days a week, but the level of staffing varies with the activation level.

The CEMP establishes three levels of activation as follows:

- Level 3 – Monitoring Activation
  This level is a "monitoring" phase. Notification is made to those state agencies and Emergency Support Functions (ESFs) needed to take action as part of everyday responsibilities. The State Emergency Operation Center is staffed with State Warning Point Communicators and DEM staff.
- Level 2 – Partial Activation of SERT
  This level is limited activation with all primary or lead ESFs notified. The State Emergency Operations Center will be staffed by DEM personnel and necessary ESFs.
- Level 1 – Full Activation

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[1] Sections 252.31-60, F.S.
[2] Section 252.32(1), F.S.
[3] Section 252.32(2), F.S.
[4] Section 14.2016, F.S.
[5] Section 252.35(2)(a), F.S.
[6] *See* Florida Division of Emergency Management (DEM), *State of Florida 2014 Comprehensive Emergency Management Plan (2014 CEMP), available at*: http://floridadisaster.org/cemp.htm (last visited January, 11, 2016).
[7] *Id.*, at 18. Alternatively, the SERT can be activated by the Governor, or the SERT Chief. *See* 2014 CEMP, Section IV H, Activation of Emergency Facilities.
[8] *Id.*, at 12-17.

This level is full scale activation and all primary and support agencies under the state plan are notified. The State Emergency Operations Center is staffed by DEM personnel and all ESFs. [9]

In order to receive federal assistance, the Governor of the state requesting funding must demonstrate direct execution of the State's emergency plan.[10] The Federal Coordinating Officer (FCO) works in unison with the State Coordinating Officer (SCO) to coordinate the federal response to a state affected by a disaster or emergency.[11]

Federal Emergency Declaration Process

When state and local resources are inadequate to effectively respond to a disaster or emergency, a state governor may request federal assistance.[12] The Governor's written request for federal assistance is made through the regional Federal Emergency Management Agency (FEMA) office after a preliminary damage assessment (PDA) has been completed.[13] The PDA assesses the costs associated with emergency protective measures, debris removal, and damage to infrastructure.[14] . In the case of an emergency, Florida sends its PDA to Region IV, located in Atlanta, Georgia.[15] However, if a severe or catastrophic event occurs, the Governor's request may be submitted prior to the PDA.

The Governor's request for federal assistance must demonstrate that appropriate action has occurred under state law and that the state's emergency plan has been initiated, among other things. After completion of the Governor's request, the President may activate federal programs to assist in the response and recovery effort. Not all federal programs are activated for every disaster.

These federal programs providing assistance are organized within the Emergency Support Functions (ESF) framework. The ESF provides the structure and coordination of federal interagency support in the event of an incident.[16] The ESF is structured upon fifteen annexes. Within each annex, federal agencies that engage in work within that functional area are labeled as primary or support agencies. Primary agencies have significant roles, resources, or capabilities necessary for emergency support within the ESF annex. Support agencies assist primary agencies in responding to an incident or providing necessary resources.[17]

The needs of the state requesting assistance determine which federal programs are activated within the ESF framework.[18] There are three activation levels and a "watch steady state" recognized by FEMA for the National Response Coordination Center. The federal levels of activation are described as follows:

- Watch Steady State
  - No event or incident anticipated.
- Level III
  - Requires moderate direct federal assistance.
  - Typically a recovery effort with minimal response requirements.

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[9] DEM, *State Emergency Operations Center Activation Levels, available at*: http://www.floridadisaster.org/eoc/eoclevel.htm (last visited Dec. 1, 2015).
[10] FEMA, *The Declaration Process, available at:* https://www.fema.gov/declaration-process (last visited Dec. 3, 2015).
[11] *Supra*, note 10 at 21-22.
[12] Public Law No: 100-707.
[13] *Supra*, note 14.
[14] DEM, *Public Assistance Program, available at*: http://www.floridadisaster.org/Recovery/PublicAssistance/Index.htm (last visited Dec. 3, 2015).
[15] DEM, *Declaration Process – Request for Presidential Disaster Declaration, available at*: http://www.floridadisaster.org/Recovery/IndividualAssistance/DeclarationProcess/Index.htm (last visited Dec. 3, 2015).
[16] FEMA, *EMERGENCY SUPPORT FUNCTION ANNEXES: INTRODUCTION, available at*: www.fema.gov/pdf/emergency/nrf/nrf-esf-intro.pdf
[17] FEMA, *Primary and Support Agencies, available at*: https://emilms.fema.gov/IS293/MAO0103070text.htm
[18] *Supra*, note 14.

    - Federal assistance may be limited to activation of only one or two ESF primary agencies.
- Level II
    - Requires a high amount of federal assistance.
    - Significant involvement of FEMA, and other federal agencies.
    - Possible deployment of initial response resources are required to support the needs of the affected state.
- Level II
    - An incident of such magnitude that has caused the response at the local, regional, or national-level to be completely overwhelmed or broken.
    - Requires an extreme amount of direct federal assistance for response and recovery efforts.
    - Major involvement of FEMA, other Federal agencies, and all primary ESF agencies are activated.[19]

Effect of Proposed Changes

This bill clarifies the term "activate" as it relates to the activation of the State Emergency Response Team (SERT) within the State Emergency Operations Center (SEOC) or at an alternate facility pursuant to the State Emergency Management Act. "Activate" is defined as "the execution and implementation of the necessary plans and activities required to mitigate, respond to, or recover from a potential or actual state of emergency or disaster declared pursuant to this chapter and the state comprehensive emergency management plan which specifies levels of activation."

The federal declaration process requires the state to 'execute' the state emergency plan in response to a disaster. Florida guidelines do not require the entire SEOC to be activated in order to respond to a disaster, portions of the SERT can be activated to provide assistance under the Comprehensive Emergency Management Plan (CEMP). The definition is intended to clarify that activating portions of the SERT constitutes execution of the state emergency plan to aid in the federal reimbursement process.

B. SECTION DIRECTORY:

Section 1: Amends s. 252.34, F.S., relating to definition under the State Emergency Management Act, defining the term "activate."

Section 2: Amends s. 163.360(10), F.S., relating to community redevelopment plans, conforming a statutory cross-reference.

Section 3: Amends s. 474.2125(1), F.S., relating to the issuance of a temporary license to a licensed veterinarian, conforming a statutory cross-reference.

Section 4: Amends s. 627.659(4), F.S., relating to blanket health insurance, conforming a statutory cross-reference.

Section 5: Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[19] FEMA, *National Incident Support Manual, available at:* https://www.fema.gov/media-library/assets/documents/24921 (last visited Dec. 9, 2015).

1. Revenues:

   None.

2. Expenditures:

   The Division of Emergency Management notes that they are not aware of any fiscal impact on the state due to the bill.[20]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The Division of Emergency Management notes that they are not aware of any fiscal impact on local governments due to the bill.[21]

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[20] DEM bill analysis of HB 1169. On file with the Appropriation Committee.
[21] *Id.*

1 A bill to be entitled
2 An act relating to emergency management; amending s.
3 252.34, F.S.; defining the term "activate" for
4 purposes of part I of ch. 252, F.S.; amending ss.
5 163.360, 474.2125, and 627.659, F.S.; conforming
6 cross-references; providing an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Present subsections (1) through (9) of section
11 252.34, Florida Statutes, are renumbered as subsections (2)
12 through (10), respectively, and a new subsection (1) is added to
13 that section, to read:
14 252.34 Definitions.—As used in this part, the term:
15 (1) "Activate" means the execution and implementation of
16 the necessary plans and activities required to mitigate, respond
17 to, or recover from a potential or actual state of emergency or
18 disaster declared pursuant to this chapter and the state
19 comprehensive emergency management plan which specifies levels
20 of activation.
21 Section 2. Subsection (10) of section 163.360, Florida
22 Statutes, is amended to read:
23 163.360 Community redevelopment plans.—
24 (10) Notwithstanding any other provisions of this part,
25 when the governing body certifies that an area is in need of
26 redevelopment or rehabilitation as a result of an emergency

27 under s. 252.34(4) ~~s. 252.34(3)~~, with respect to which the
28 Governor has certified the need for emergency assistance under
29 federal law, that area may be certified as a "blighted area,"
30 and the governing body may approve a community redevelopment
31 plan and community redevelopment with respect to such area
32 without regard to the provisions of this section requiring a
33 general plan for the county or municipality and a public hearing
34 on the community redevelopment.
35 Section 3. Subsection (1) of section 474.2125, Florida
36 Statutes, is amended to read:
37 474.2125 Temporary license.—
38 (1) The board shall adopt rules providing for the issuance
39 of a temporary license to a licensed veterinarian of another
40 state for the purpose of enabling her or him to provide
41 veterinary medical services in this state for the animals of a
42 specific owner or, as may be needed in an emergency as defined
43 in s. 252.34(4) ~~s. 252.34(3)~~, for the animals of multiple
44 owners, provided the applicant would qualify for licensure by
45 endorsement under s. 474.217. No temporary license shall be
46 valid for more than 30 days after its issuance, and no license
47 shall cover more than the treatment of the animals of one owner
48 except in an emergency as defined in s. 252.34(4) ~~s. 252.34(3)~~.
49 After the expiration of 30 days, a new license is required.
50 Section 4. Subsection (4) of section 627.659, Florida
51 Statutes, is amended to read:
52 627.659 Blanket health insurance; eligible groups.—Blanket

53 health insurance is that form of health insurance which covers
54 special groups of individuals as enumerated in one of the
55 following subsections:
56 (4) Under a policy or contract issued in the name of a
57 volunteer fire department, first aid group, local emergency
58 management agency as defined in s. 252.34(6) ~~s. 252.34(5)~~, or
59 other group of first responders as defined in s. 112.1815, which
60 is deemed the policyholder, covering all or any grouping of the
61 members or employees of the policyholder or covering all or any
62 participants in an activity or operation sponsored or supervised
63 by the policyholder.
64 Section 5. This act shall take effect upon becoming a law.

CS/HB 4065

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 4065 Duties of Legislative Auditing Committee
SPONSOR(S): Government Operations Subcommittee; Raulerson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Government Operations Subcommittee	13 Y, 0 N, As CS	Moore	Williamson
2) Appropriations Committee		Delaney	Leznoff

SUMMARY ANALYSIS

The Legislative Auditing Committee (Committee) is a joint committee comprised of five members of the Florida House of Representatives and five members of the Florida Senate. Current law authorizes the Committee to investigate any matter within the scope of an audit, review, or examination either completed by or being conducted by the Auditor General or the Office of Program Policy Analysis and Government Accountability and, in connection with such investigation, to exercise subpoena powers.

The bill repeals the requirement for the Auditor General to notify the Committee of any financial or operational audit report that indicates that a state university or Florida College System institution has failed to take full corrective action in response to a recommendation that was included in the two preceding financial or operational audit reports. The bill also repeals the Committee's responsibilities to investigate and refer such instances of noncompliance.

The bill repeals the Committee's responsibilities with respect to the Transparency Florida Act (Act), including the requirements that the Committee make recommendations regarding the websites required under the Act and prepare an annual report.

The bill does not have a significant fiscal impact on the state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Legislative Auditing Committee

The Legislative Auditing Committee (Committee) is a joint committee comprised of five members of the Florida House of Representatives and five members of the Florida Senate. Section 11.40, F.S., authorizes the Committee to investigate any matter within the scope of an audit, review, or examination either completed by or being conducted by the Auditor General or the Office of Program Policy Analysis and Government Accountability and, in connection with such investigation, to exercise subpoena powers.

Auditor General

The Auditor General is appointed by the Legislature to conduct audits of records and to perform related duties as prescribed by law.[1] Such duties include, but are not limited to:

- Conducting financial audits of state government, state universities, state colleges, and district school boards;
- Conducting operational and performance audits of accounts and records of state agencies, state universities, state colleges, district school boards, the Florida Clerks of Court Operations Corporation, water management districts, and the Florida School for the Deaf and the Blind;
- Conducting performance audits of local government financial reporting systems; and
- Conducting performance audits of the Department of Revenue's administration of the ad valorem tax laws.[2]

The Auditor General is required to notify the Committee of any financial or operational audit report that indicates that a district school board, state university, or Florida College System institution has failed to take full corrective action in response to a recommendation that was included in the two preceding financial or operational audit reports.[3] The Committee is authorized to direct the audited entity to provide a written statement explaining why full corrective action has not been taken or what corrective action is intended to be taken and when it will occur.[4] If the Committee determines that the audited entity has failed to take full corrective action for which there is no justifiable reason or has failed to comply with the Committee's requests, the Committee must refer the matter to the State Board of Education or the Board of Governors, as appropriate, to investigate the noncompliance.[5]

Transparency Florida Act

The Transparency Florida Act (Act) requires specified governmental fiscal information to be made publicly available via website or management system.[6] The Act requires the Governor, in consultation with the appropriations committees of the House of Representatives and the Senate, to maintain a central website providing access to all other websites required by the Act. The law requires certain budget information, certain contract information, and minimum functionality standards to be readily available online.

Pursuant to the Act, the Committee is required to annually recommend to the President of the Senate and the Speaker of the House of Representatives:

- Additional information to be added to a website, such as whether to expand the scope of the information provided to include state universities, Florida College System institutions, school

[1] *See* art. III, s. 2, Fla. Const., and s. 11.45(2)(a), F.S.
[2] *See* s. 11.45(2)(a), F.S.
[3] Section 11.45(7)(j), F.S.
[4] Section 11.45(7)(j)1., F.S.
[5] Section 11.45(7)(j)3., F.S.
[6] Section 215.985, F.S.

districts, charter schools, charter technical career centers, local government units, and other governmental entities.
- A schedule for adding information to the website by type of information and governmental entity, including timeframes and development entity.
- A format for collecting and displaying the additional information.[7]

The manager of each website required under the Act must submit to the Committee information related to the cost of creating and maintaining the website and the number of times the website has been accessed.[8] The Committee is required to coordinate with the Financial Management Information Board in developing recommendations for including information on the website.[9] Each year, the Committee must prepare a report detailing progress in establishing the single website and providing recommendations for enhancement of the content and format of the website and related policies and procedures. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1.[10]

Effect of Proposed Changes

The bill repeals the requirement for the Auditor General to notify the Committee of any financial or operational audit report that indicates that a state university or Florida College System institution has failed to take full corrective action in response to a recommendation that was included in the two preceding financial or operational audit reports. The bill also repeals the Committee's responsibilities to investigate and refer such instances of noncompliance.

The bill repeals the Committee's responsibilities with respect to the Transparency Florida Act (Act), including the requirements that the Committee make recommendations regarding the websites required under the Act and prepare an annual report.

B. SECTION DIRECTORY:

Section 1 amends s. 11.45, F.S., relating to the Auditor General.

Section 2 amends s. 215.985, F.S., relating to transparency in government spending.

Section 3 amends s. 1002.396, F.S., correcting a cross-reference.

Section 4 provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues: None
2. Expenditures:

   The bill does not have a significant impact on state government expenditures. The workload associated with the responsibilities being eliminated is nominal.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[7] Section 11.45(7), F.S.
[8] Section 11.45(8), F.S.
[9] Section 11.45(9), F.S.
[10] Section 11.45(13), F.S.

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 26, 2016, the Government Operations Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment removed the provisions of the bill relating to audits of compensation reports of legislative branch and executive branch lobbying firms.

This analysis is drafted to the committee substitute as approved by the Government Operations Subcommittee.

1 A bill to be entitled
2 An act relating to duties of the Legislative Auditing
3 Committee; amending s. 11.45, F.S.; removing a
4 requirement that the Auditor General notify the
5 committee regarding certain financial or operational
6 audit reports of state universities or Florida College
7 System institutions; removing duties of the committee
8 relating to state universities or Florida College
9 System institutions that have failed to take
10 corrective action based on such reports; amending s.
11 215.985, F.S.; repealing provisions requiring the
12 committee's input related to the website of the
13 Executive Office of the Governor; amending s.
14 1002.395, F.S.; correcting a cross-reference;
15 providing an effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. Paragraph (j) of subsection (7) of section
20 11.45, Florida Statutes, is amended to read:
21 11.45 Definitions; duties; authorities; reports; rules.—
22 (7) AUDITOR GENERAL REPORTING REQUIREMENTS.—
23 (j) The Auditor General shall notify the Legislative
24 Auditing Committee of any financial or operational audit report
25 prepared pursuant to this section which indicates that a
26 district school board~~, state university, or Florida College~~

27 ~~System institution~~ has failed to take full corrective action in
28 response to a recommendation that was included in the two
29 preceding financial or operational audit reports.
30 1. The committee may direct the district school board ~~or~~
31 ~~the governing body of the state university or Florida College~~
32 ~~System institution~~ to provide a written statement to the
33 committee explaining why full corrective action has not been
34 taken or, if the district school board ~~governing body~~ intends to
35 take full corrective action, describing the corrective action to
36 be taken and when it will occur.
37 2. If the committee determines that the written statement
38 is not sufficient, the committee may require the chair of the
39 district school board ~~or the chair of the governing body of the~~
40 ~~state university or Florida College System institution,~~ or the
41 chair's designee~~,~~ to appear before the committee.
42 3. If the committee determines that the district school
43 board~~, state university, or Florida College System institution~~
44 has failed to take full corrective action for which there is no
45 justifiable reason or has failed to comply with committee
46 requests made pursuant to this section, the committee shall
47 refer the matter to the State Board of Education ~~or the Board of~~
48 ~~Governors, as appropriate,~~ to proceed in accordance with s.
49 1008.32 ~~or s. 1008.322, respectively~~.
50 Section 2. Subsections (2), (7), (8), (9), and (13) of
51 section 215.985, Florida Statutes, are amended to read:
52 215.985 Transparency in government spending.—

53 (2) As used in this section, the term:
54 ~~(a) "Committee" means the Legislative Auditing Committee~~
55 ~~created in s. 11.40.~~
56 (a) ~~(b)~~ "Contract" means a written agreement or purchase
57 order issued for the purchase of goods or services or a written
58 agreement for the receipt of state or federal financial
59 assistance.
60 (b) ~~(c)~~ "Governmental entity" means a state, regional,
61 county, municipal, special district, or other political
62 subdivision whether executive, judicial, or legislative,
63 including, but not limited to, a department, division, bureau,
64 commission, authority, district, or agency thereof, or public
65 school, Florida College System institution, state university, or
66 associated board.
67 (c) ~~(d)~~ "Website" means a site on the Internet which is
68 easily accessible to the public at no cost and does not require
69 the user to provide information.
70 ~~(7) By November 1, 2013, and annually thereafter, the~~
71 ~~committee shall recommend to the President of the Senate and the~~
72 ~~Speaker of the House of Representatives:~~
73 ~~(a) Additional information to be added to a website, such~~
74 ~~as whether to expand the scope of the information provided to~~
75 ~~include state universities, Florida College System institutions,~~
76 ~~school districts, charter schools, charter technical career~~
77 ~~centers, local government units, and other governmental~~
78 ~~entities.~~

79 ~~(b) A schedule for adding information to the website by~~
80 ~~type of information and governmental entity, including~~
81 ~~timeframes and development entity.~~
82 ~~(c) A format for collecting and displaying the additional~~
83 ~~information.~~
84 ~~(8) The manager of each website described in subsections~~
85 ~~(4), (5), and (6) shall submit to the committee information~~
86 ~~relating to the cost of creating and maintaining such website,~~
87 ~~and the number of times the website has been accessed.~~
88 ~~(9) The committee shall coordinate with the Financial~~
89 ~~Management Information Board in developing recommendations for~~
90 ~~including information on the website which is necessary to meet~~
91 ~~the requirements of s. 215.91(8).~~
92 ~~(13) The committee shall prepare an annual report~~
93 ~~detailing progress in establishing the single website and~~
94 ~~providing recommendations for enhancement of the content and~~
95 ~~format of the website and related policies and procedures. The~~
96 ~~report shall be submitted to the Governor, the President of the~~
97 ~~Senate, and the Speaker of the House of Representatives by~~
98 ~~November 1.~~
99 Section 3. Paragraph (d) of subsection (9) of section
100 1002.395, Florida Statutes, is amended to read:
101 1002.395 Florida Tax Credit Scholarship Program.—
102 (9) DEPARTMENT OF EDUCATION OBLIGATIONS.—The Department of
103 Education shall:
104 (d) Annually verify the eligibility of expenditures as

105 provided in paragraph (6)(d) using the audit required by
106 paragraph (6)(m) and s. 11.45(2)(j) ~~11.45(2)(k)~~.
107 Section 4. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7089 PCB HHSC 16-01 State Group Insurance Program
SPONSOR(S): Health & Human Services Committee, Brodeur and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1434

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	13 Y, 3 N	Poche	Calamas
1) Appropriations Committee		Delaney	Leznoff

SUMMARY ANALYSIS

The State Group Insurance Program (program), administered by the Department of Management Services (DMS), is an optional benefit for employees that includes health, life, dental, vision, disability, and other supplemental insurance benefits. The program offers employees a choice among a health maintenance organization (HMO) plan, prefer provider plan (PPO) plan, and a high-deductible health plan (HDHP) with a health saving account (HSA). However, only one benefit level is offered for each plan type. Additionally, the employee's premium for the HMO and PPO are the same, even though the HMO provides greater benefits.

HB 7089 adds new products and services to the program by giving DMS broad authority to contract for a wide variety of additional products and services. Employees will be able to purchase new products as optional benefits. DMS is directed to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other types of medical procedures. The contract requires cost savings to the program, which will be shared by the state and the enrollee.

Beginning in 2017, DMS is directed to contract with at least one entity that provides online health care price and quality information, including the average price paid for health care services and providers by county. The contract requires the entity to allow enrollees to shop for health care using the information provided to select higher quality, lower cost services and providers. The contract also requires the entity to identify any savings realized by the enrollee, and share those savings with the enrollee

Beginning in the 2019 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. If the state's contribution for premium is more than the cost of the plan selected by the employee, then the employee may use the remainder to:

- Fund a flexible spending arrangement or a health savings account.
- Purchase additional benefits offered through the state group insurance program.
- Increase the employee's salary.

The bill directs DMS to hire an independent benefits consultant (IBC). The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2018. The IBC will also provide ongoing assessments and analysis for the program.

The bill directs DMS to recommend employee contribution rates for standard plans and high deductible health plans for the 2017 plan year reflecting the actual benefit difference between the HMO and the PPO plans for both self-insured and fully insured products. The proposed enrollee premium rates for the 2017 plan year must be submitted to the Legislative Budget Commission (LBC) for review and approval. If the LBC does not approve the proposed rates, the rates provided in the 2016-17 General Appropriations Act will apply.

The bill provides $151,216 in recurring trust fund and $507,546 in nonrecurring trust fund authority to the Department of Management Services, and 2 full-time equivalent positions to implement the administrative provision of the act. The provisions of the bill are expected to have an indeterminate fiscal impact on the state. See fiscal comments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

State Group Insurance Program

Overview

The State Group Insurance Program (state program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS or department).

The state program is an optional benefit for all state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

The health insurance benefit for active employees has premium rates for single, spouse program[1], or family coverage regardless of plan selection. The state contributed approximately 91% toward the total annual premium for active employees for a total of $1.68 billion out of total premium of $1.85 billion for active employees during FY 2014-15[2]. Retirees and COBRA participants contributed an additional $228.4 million in premiums, with $139.4 million more in other revenue for a total of $2.2 billion in total revenues.[3]

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under Section 125 of the Internal Revenue Code. Employees choose from a "menu" of benefits. The plan can provide a number of selections, including medical, accident, disability, vision, dental and group term life insurance. It can reimburse actual medical expenses or pay children's day care expenses.

A cafeteria plan reduces both the employer's and employee's tax burden. Contributions by the employer are not subject to the employer social security contribution. Contributions made by the employee are not subject to federal income or social security taxes.

The employer chooses the range of benefits it wishes to offer in a cafeteria plan. The plan can be a simple premium-only plan where only health insurance is offered. Full flex plans, which offer a wide variety of benefits and choices, are more often offered by large employers and allow for more consumer-directed consumption of benefits. In some full flex plans, the employee is offered the choice between receiving additional compensation in lieu of benefits.

The state program qualifies as a cafeteria plan[4] even though it offers relatively narrow health plan options compared to other cafeteria plans.

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[1] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[2] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, *State Employees' Group Health Self-Insurance Trust Fund- Report on the Financial Outlook for Fiscal Years Ending June 30, 2015 through June 30, 2020*, adopted August 12, 2015, page 6, available at http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf
[3] Id.
[4] 26 USC sec. 125 requires that a cafeteria plan allow its members to choose between two or more benefits "consisting of cash and qualified benefits." The proposed regulations define "cash" to include a "salary reduction arrangement" whereby salary is deducted pre-tax to pay the employee's share of the insurance premium. Since the state program allows a "salary reduction arrangement", the program qualifies as a cafeteria plan. 26 C.F.R. ss. 1.125-1, et seq.

Health Plan Options

The program provides limited options for employees to choose as their health plan. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Florida Blue, whose current contract is for the 2015 through 2018 plan years. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs[5].

Prior to the 2011 plan year, the participating HMOs were fully insured; in other words, the HMOs assumed all financial risk for the covered benefits. During the 2010 session, the Legislature enacted s. 110.12302, F.S., which directed DMS to require costing options for both fully insured and self-insured plan designs as part of the department's solicitation for HMO contracts for the 2012 plan year and beyond. The department included these costing options in its Invitation to Negotiate[6] to HMOs for contracts for plans years beginning January 1, 2012. The department entered into contracts for the 2012 and 2013 plan years with two HMOs with a fully insured plan design and four with a self-insured plan design. The contracts with the HMOs have been renewed for the 2015 plan year.[7]

Additionally, the program offers two high-deductible health plans (HDHP[8]) with health savings accounts (HSAs)[9]. The Health Investor PPO Plan is the statewide HDHP with an integrated HSA. It is also administered by Florida Blue. The Health Investor HMO Plan is an HDHP with an integrated HSA in which the state has contracted with multiple state and regional HMOs. Both have an individual deductible of $1,350 for individual and $2,600 for family for network providers. The state makes a $500 per year contribution to the HSA for single coverage and a $1,000 per year contribution for family coverage. The employee may make additional annual contributions[10] to a limit of $3,350 for single coverage and $6,650 for family coverage. Both the employer and employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. An HSA is owned by the employee and is portable.

The following charts illustrate the benefit design of each of the plan choices.

	HMO Standard	PPO Standard	
	Network Only	Network	Out-of-Network
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist	$40 copayment	$25 copayment	
Urgent Care	$25 copayment	$25 copayment	
Emergency Room	$100 copayment	$100 copayment	

[5] The HMOs include Aetna, AvMed, Capital Health Plan, Coventry Health Care of Florida, Florida Health Care Plans and UnitedHealthcare.
[6] ITN NO.: DMS 10/11-011
[7] DMS is currently procuring HMOs for the next contract period and expects to complete the procurement process and award contracts to the HMOs after the 2016 Regular Legislative Session.
[8] High-deductible health plans with linked HSAs are also call consumer-directed health plans (CDHP) because costs of health care are more visible to the enrollee.
[9] 26 USC sec. 223; To qualify as a high-deductible plan, the annual deductible must be at least $1,300 for single plans and $2,600 for family coverage, but annual out-of-pocket expenses cannot exceed $6,450 for individual and $12,900 for family coverage. These amounts are adjusted annually by the IRS.
[10] The IRS annually sets the contribution limit as adjusted by inflation.

Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between the charge and the allowance
Generic | Preferred | Non-Preferred Prescriptions	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail	Pay in full, file claim
	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order	
Out-of-Pocket Maximum	$1,500 | $3,000 Single | Family	$2,500 | $5,000 (coinsurance only) Single | Family	

	PPO and HMO Health Investor	
	Network	Out-of-Network (PPO Only)
Deductible	$1,300 | $2,600 Single | Family	$2,500 | $5,000 Single | Family
Primary Care	After meeting deductible, 20% of network allowed amount	After meeting deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist		
Urgent Care		
Emergency Room		
Hospital Stay		After meeting deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance
Generic | Preferred | Non-Preferred Prescriptions	After meeting deductible , 30% | 30% | 50% Retail and Mail Order	Pay in full, file claim
Out-of-Pocket Maximum	$3,000 | $6,000 (coinsurance only) Single | Family	$7,500 | $15,000 (coinsurance only) Single | Family

Flexible Spending Accounts

Currently, the state program offers flexible spending accounts (FSAs)[11] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[12]. The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Prior to 2013, there was no limit on the contribution to a FSA; however, it is now limited to $2,500 and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.[13] If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

[11] Sec. 125 I.R.C.; *see* IRS Publication 969 (2014) available at https://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed on January 15, 2016).
[12] Employers are also allowed to contribute to FSAs.
[13] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.

Health Reimbursement Arrangements

Health reimbursement arrangements (HRAs) are defined contribution benefits established by an employer for their employees. Each year, an employer determines a specified amount, or a defined contribution benefit, of pre-tax dollars to assist employees with medical expenses. The employer can determine minimum and maximum contribution amounts; there are no federal limits. Typically associated with an HDHP, an HRA is entirely funded by the employer and provides tax-free reimbursements to employees for medical expenses.[14] Unlike a FSA, an HRA is not a "use it or lose it" arrangement, but the employer may cap the rollover amount. The state program does not currently offer HRAs.

The following chart shows the distinctions among FSAs, HSAs, and HRAs:

	FSA	HSA	HRA
Who funds the account?	Employee and employer (optional)	Employee, employer, and other individuals	Employer
How is it funded?	Employee payroll deduction; employer direct contribution - money is held by employer in "fund"	Cash contributions to bank account owned by employee	Employer pays up to promised amount
Account Owner	Employer	Employee	Employer
Contribution Limits	$2,550 annually	Single - $3,350 Family - $6,750 Over 55 - additional $1,000 for single coverage	Set by employer
Rollover of Funds?	Up to $500 (federal law)	Yes	Yes, as determined by employer
Medical Expenses Allowed	IRC 213(d) expenses;[15] No personal health insurance	IRC 213(d) expenses; No employer limitations	Health insurance premiums and IRC 213(d) expenses, as determined by employer
High Deductible Health Plan Required?	No	Yes Minimum deductible: Single - $1,300 Family - $2,600 Max out-of-pocket: Single - $6,550 Family - $13,100	No

Employer and Employee Contributions

The state program is considered employer-sponsored since the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state's employer contribution is part of a state employee's overall compensation. The state program is a defined-benefit program. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the remainder. The following chart shows the monthly contributions[16] of the state and the employee to employee health insurance premium.

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[14] An HRA can only be used for qualified medical expenses defined under s. 213(d), I.R.C., including health insurance and long-term care insurance.

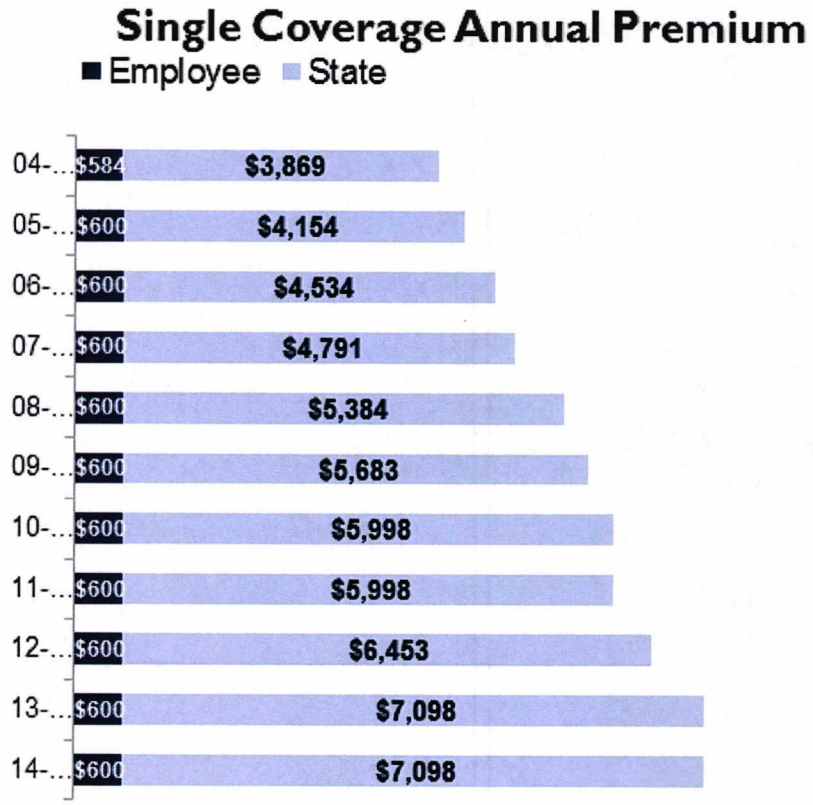
[15] S. 213(d), I.R.C., permits the deduction of expenses paid for medical care of the taxpayer, his or her spouse, or a dependent. Medical care includes amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease; transportation necessary for medical care; qualified long-term care services; and health insurance or long-term care insurance.

[16] Department of Management Services, State Employees' Group Health Self-Insurance Trust Fund, *Premium Rate Table Effective December 2015 for January 2016 Coverage,* available at http://mybenefits.myflorida.com/content/download/118950/652870/DSGI_-_Premium_Table_Effective_December_2015_for_January_2016_Coverage.pdf (last viewed on January 15, 2016).

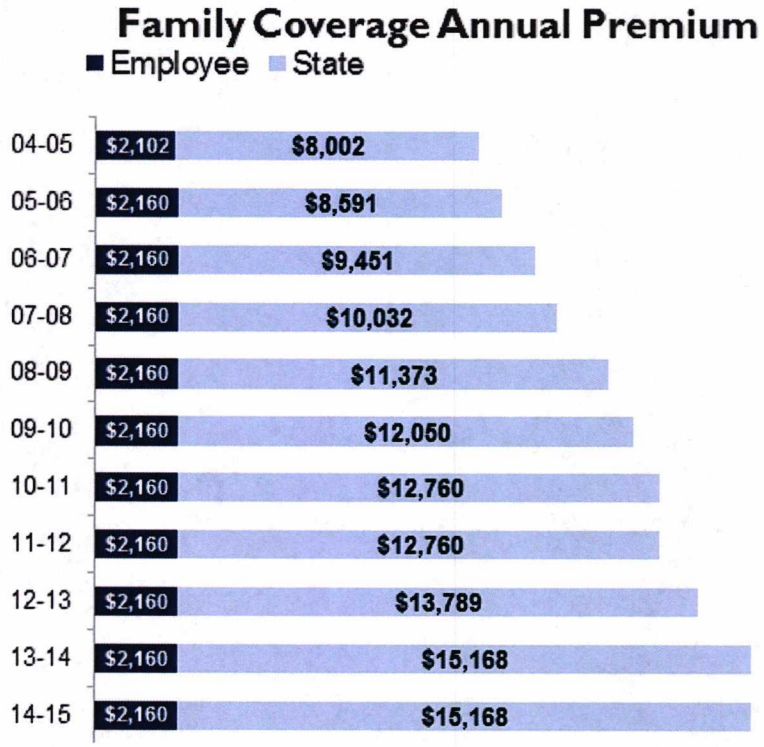
Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career Service/ OPS	Single	$591.52	$50.00	$641.52	$591.52	$15.00	$606.52
	Family	$1,264.06	$180.00	$1,444.06	$1,264.06	$64.30	$1,328.36
	Spouse	$1,429.08	$30.00	$1,459.08	$1,298.36	$30.00	$1,328.36
"Payalls" (SES/SMS)	Single	$637.34	$8.34	$645.68	$598.18	$8.34	$606.52
	Family	$1,429.06	$30.00	$1,459.06	$1,298.36	$30.00	$1,328.36

* Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month ($500 and $1,000 annually) for single and family coverage, respectively

The state program is projected to spend $2.24 billion in FY 2015-2016 in health benefit costs.[17] The aggregate annual spending growth rate of the program is 9.5%. The state has absorbed almost all of the cost of the increase and employee contributions have remained the same for the last nine years as illustrated by the following charts.[18]



[17] Supra, FN 2, page 4.
[18] Department of Management Services, *Overview of the State Group Health Insurance Program,* presentation to the Health and Human Services Committee on March 12, 2015, slide 15 (on file with Committee staff).



Plan Enrollment

The state program has 360,821 covered lives and 171,794 policyholders.[19] Currently, 50.3% of enrollees chose the standard HMO and 48.3 % chose the standard PPO.[20] Only 1.4% of enrollees chose either HDHP.[21] During the open enrollment period for 2015, PPO enrollment increased slightly, by 0.05%, and HMO enrollment decreased by 0.46%.[22] Five year Open Enrollment trends show that annual enrollment in the PPO plans decreased.[23]

Employer Sponsored Insurance Trends

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[24] (report) for the state. The report compares Florida's program to the programs of other large employers[25], both in the public and in the private sectors. The report found that the State of Florida contributes a higher percentage of the premium to employee health benefits than other states and private employers. At the time, Florida paid 84% of the monthly premium for a family PPO plan, but the average for large national employers was 69%. This results in Florida state employees paying less in monthly premiums than other states' employees and private employees. For example, the monthly premium for a family PPO plan for a Florida state employee is $180 and in 2011, the average premium for large national employers was $361.

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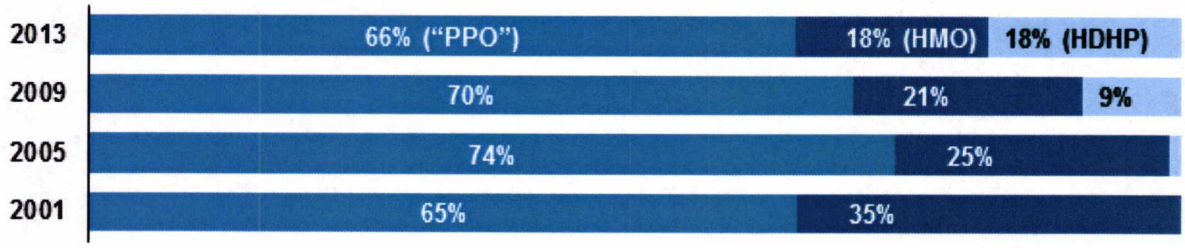
[19] Supra, FN 2, page 1.
[20] Id.
[21] Id. at page 2.
[22] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, State Employees' Group Health Self-Insurance Trust Fund, *Report on the Financial Outlook*, March 9, 2015, page 1, available at http://edr.state.fl.us/Content/conferences/healthinsurance/archives/150309healthins.pdf (last viewed on January 15, 2016).
[23] Id.
[24] Mercer Consulting, *State of Florida Benchmarking Report*, March 24, 2011, available at: http://www.dms.myflorida.com/content/download/81475/468865/version/1/file/2010+Small+Employer+Benchmarking+Report+for+State+of+Florida.pdf.
[25] For the purpose of the report, "large employers" had 500 or more employees.

Today, the monthly premium for a family PPO plan for a Florida state employee is still $180; however, the state now pays 88% of the premium[26] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[27]

The national trend among large employer health plans is increasing enrollment in high-deductible health plans (HDHP) and declining enrollment in HMOs as illustrated in the following chart[28]:



The state program's trend is the reverse of the national trend in HMO, PPO, and HDHP because of the HMO's high actuarial value and no difference in premiums between the HMO and PPO. The actuarial value (AV) measures the percentage of expected medical costs that a health plan will cover and is generally considered a measure of the health plan's generosity. The state program's standard HMO as an AV of 92.6%, the standard PPO has an AV of 88.9%, and the HDHP has an AV of 80%.[29] Accordingly, enrollees in the state program gravitate toward the high value, low cost HMO because they experience no price difference between the plans.

Employee Choice

The FY 2011-2012 General Appropriations Act directed DMS to develop a report of plan alternatives and options for the state program. DMS contracted with Buck Consultants which released its report[30] on September 29, 2011. The report concludes:

> The state's current approach to its health plan is best described as paternalistic, whereby the state serves as the architect/custodian of the plan, providing generous benefits and allowing employees to be passive and perhaps even entitled, with little concern about costs. Historically prevalent among large and governmental employers, this approach is rapidly being replaced by initiatives that focus on increasing and improving consumerism behaviors. In the consumerism approach the employer and employees maintain shared accountability, with the employer providing a supportive environment, partnering with employees and enabling them to make informed decisions, considering costs and outcomes of the health care services they seek and receive.

In a presentation before the Health and Human Services Committee on January 16, 2014, Mercer Health & Benefits (Mercer) reported that the state program is behind other large employers in key survey trends.[31] The state program has plans with lower employee premiums and higher benefits than industry benchmarks.[32] There is virtually no enrollment in HDHPs versus significant growth nationally.[33] Florida's plan costs and annual trend increase are higher than national survey data.[34] State employees have little real choice among health plan options since there is only a 4 percent difference in the

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[26] The state contributes 92% of the premium for the individual PPO plan.
[27] *Market-Based Framework for Health Plan Program Changes*, Mercer Health & Benefits, presentation to the Health and Human Services Committee on January 16, 2014, at slide 18.
[28] Id. at slide 6.
[29] Foster and Foster, *Actuarial Value Contribution Analysis,* March 20, 2015 at page 3.
[30] Buck Consultants, *Strategic Health Plan Options for the State of Florida* (September 29, 2011), available at: http://www.dms.myflorida.com/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf (last viewed on January 15, 2016).
[31] Supra, FN 24 at slide 5.
[32] Id.
[33] Id.
[34] Supra, FN 24 at slide 6.

"richness of the benefits" between the HMO and PPO, and the price is the same.[35] Consequently, 99 percent of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[36]

Effect of the Bill

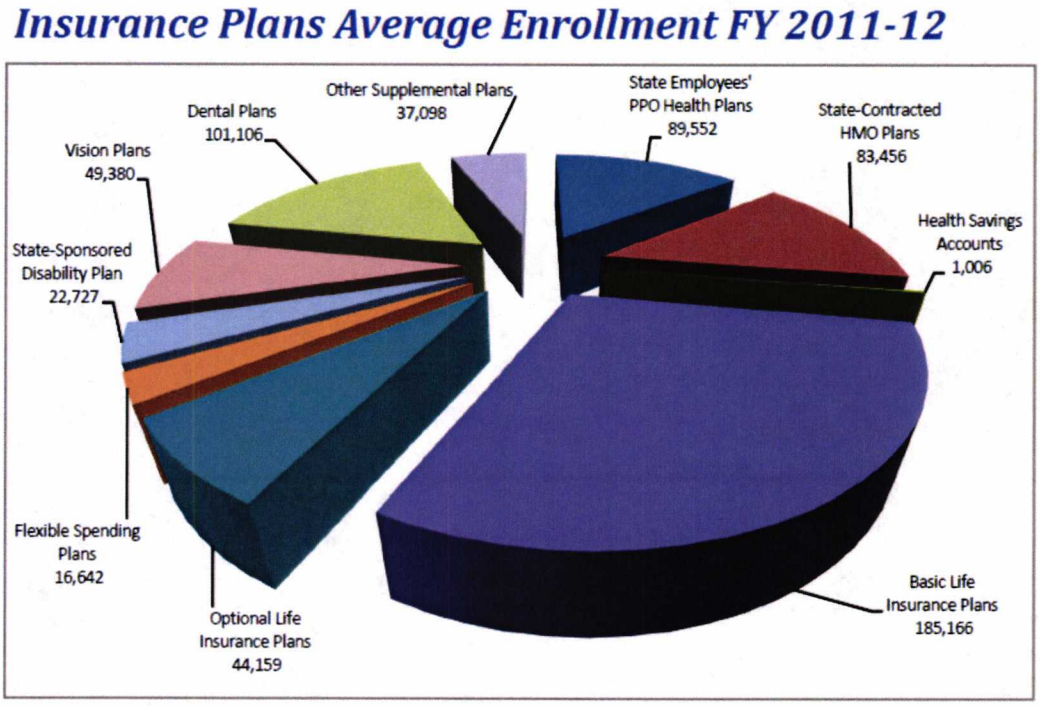
Premium Adjustments

Current law provides that "the state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees . . .participating in the same coverage tier[37] in the same plan."[38] Since there is a 4 percent difference in the actuarial value between the HMO and the PPO, the state currently pays more from the State Employees' Group Health Self-Insurance Trust Fund (Trust Fund) for the HMO benefits. However, each year the Legislature sets uniform premium amounts in the General Appropriations Act for state paid premiums. The premiums are deposited into the Trust Fund and used to pay the expenses of the state program.

Because DMS is currently procuring HMO contracts for the SGI program, the value of the benefits offered by the HMOs that will receive a contract is unknown. Employee contribution rates that reflect the different values of the HMO and the PPO cannot be determined until the conclusion of the procurement. The bill gives DMS authority to establish the employee contribution rates, and then seek approval from the Legislative Budget Commission. The bill directs DMS to determine and recommend employee contribution rates for standard plans and high deductible health plans for the 2017 plan year reflecting the actuarial benefit difference between the HMO and the PPO plans for both self-insured and fully insured products. The proposed enrollee premium rates for the 2017 plan year must be submitted to the Legislative Budget Commission (LBC) for review and approval. If the LBC does not approve the proposed rates, the rates provided in the 2016-17 General Appropriations Act will apply.

Additional Benefits

Many state employees enroll in products offered by the state program other than health insurance:



[35] Foster and Foster, *Actuarial Value Contribution Analysis,* March 20, 2015 at page 3.
[36] Supra, FN 24 at slide 9.
[37] The coverage tier is either individual or family.
[38] S. 110.123(3)(f), F.S.

The bill allows DMS to contract for additional products to be included in the state program. These include:

- Prepaid limited health service organizations as authorized under part I of chapter 636.
- Discount medical plan organizations as authorized under part II of chapter 636.
- Prepaid health clinic service providers licensed under part II of chapter 641.
- Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, and other licensed health care providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Entities that provide specific health services in accordance with applicable state law and sell service contracts and arrangements for a specified amount and type of health services.
- Entities that provide health services or treatments through a bidding process.
- Entities that provide health services or treatments through bundling or aggregating the health services or treatments.
- Entities that provide other innovative and cost-effective health service delivery methods.

The bill also directs DMS to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures. These bundled services will be another option for state employees. The entity will be required to have procedures and evidence-based standards to assure only high quality health care providers are included. Assistance must be provided to the enrollee in accessing care and in the coordination of the care. The bundled services must provide cost savings to the state program and the enrollee, which will be shared by the state and the enrollee. The cost savings payable to an enrollee can be paid:

- To the enrollee's FSA;
- To the enrollee's HSA;
- To the enrollee's HRA; or
- To the enrollee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

The selected entity must provide an educational campaign for employees to learn about the offered services.

By January 15 of each year, DMS must report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level and cost-savings to both the enrollee and the state resulting from contract.

Price Transparency and Cost Savings Sharing

The costs of health care procedures are often unknown and unknowable to consumers and can vary dramatically among providers.[39] The following chart shows the extreme price differences across the country of the average cost to Medicare for a joint replacement.

[39] *How to Bring the Price of Health Care Into the Open*, The Wall Street Journal, Melinda Beck, February 23, 2014, available at: http://online.wsj.com/news/articles/SB10001424052702303650204579375242842086688?mod=trending_now_5 (last viewed on January 15, 2016). *Does Knowing Medical Prices Save Money? CalPERS Experiment Says Yes*, Kaiser Health News, Ankita Rao, December 6, 2013, available at: http://capsules.kaiserhealthnews.org/index.php/2013/12/does-knowing-medical-prices-save-money-calpers-experiment-says-yes/ (last viewed on January 15, 2016).

	Hospital Charges	Actual Payment
Maryland	$21,230	$20,048
Delaware	$32,629	$14,765
Hawaii	$39,463	$18,512
Georgia	$46,856	$13,303
Pennsylvania	$51,014	$13,679
South Carolina	$57,557	$13,651
Arkansas	$63,290	$21,160
New Jersey	$66,639	$15,059
Nevada	$71,782	$13,621
California	$88,238	$17,187

Note: This includes all joints other than hips.
Source: Centers for Medicare & Medicaid Services, May 8, 2013

The California Public Employees' Retirement System (CalPERS), the second largest benefits program in the country started a "reference pricing" initiative in 2011. CalPERS set a threshold of $30,000 for hospital payments for both for inpatient hip and knee replacements and designated certain hospitals where enrollees could get care at or below that price. If enrollees had surgery at designated hospitals, they paid only their plans' typical deductible and coinsurance up to the out-of-pocket maximum. Patients could go to other in-network hospitals for care but were responsible for both the typical cost sharing and all allowed amounts exceeding the $30,000 threshold, which were not subject to an out-of-pocket maximum. The initiative reportedly resulted in $2.8 million savings for CalPERS and $300,000 in savings for enrollees in 2011 without sacrificing quality.[40]

The bill directs DMS to contract with at least one contract with at least one entity that provides online health care price and quality information, including the average price paid for health care services and providers by county. The contract requires the entity to allow enrollees to shop for health care using the information provided to select higher quality, lower cost services and providers. The contract also requires the entity to identify any savings realized between what the enrollee pays for a service and provider and the average price paid for the same service or provider. The bill provides for the enrollee and state to share any savings generated by the enrollee's choice of providers.

If an enrollee selects a service or provider which results in savings to the state, the state shall pay to the employee fifty percent of the difference between the average price paid for the service or provider and the price paid. The amount payable to the employee can be paid:

- To the employee's FSA;
- To the employee's HSA;
- To the employee's HRA; or
- To the employee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

By January 1 of 2018, 2019, and 2020, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, the amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the price transparency pilot project.

[40] *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer*, Center for Studying Health System Change, Amanda E. Lechner, Rebecca Gourevitch, Paul B. Ginsburg, Research Brief No. 30, December 2013, available at: http://www.hschange.org/CONTENT/1397/ (last viewed on January 15, 2016).

Additional Benefit Choices

Beginning in the 2019 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. These levels are:

- Platinum Level (at least 90% AV)
- Gold Level (at least 80% AV)
- Silver Level (at least 70% AV)
- Bronze Level (at least 60% AV)

The state will make a defined contribution for each employee toward the cost of purchasing a health plan. Employees will have the following options:

- Use the entire employer contribution to pay for health insurance and pay any additional premium if the cost of the plan exceeds the employer contribution.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a FSA.
- Use part of the employer contribution to pay for health insurance and have the balance credited to an HSA.
- Use part of the employer contribution to pay for health insurance and use the balance to purchase additional benefits offered through the state group insurance program.
- Use part of the employer contribution to pay for health insurance and have the balance used to increase the employees pay.[41]

The state currently pays 92 percent of the employee's premium for an individual plan and 88 percent for a family plan for a Platinum level plan (HMO) or a Gold level plan (PPO).

The following chart illustrates a hypothetical[42] example for a Career Service employee with a family plan and a defined contribution benchmarked using the current state contribution, current employee contribution, and the current plan cost:

Family Coverage	Current Plan 89% - 93% AV	80% AV Coverage	70% AV Coverage	60% AV Coverage
State Contribution	$15,168	$15,168	$15,168	$15,168
Plan Cost	$17,328	$14,344	$12,852	$11,361
Employee Contribution	$2,160	$0	$0	$0
Employee Receives	$0	$824	$2,316	$3,807

Under this hypothetical, the employee may choose the same value health plan as the employee has today and pay the same amount as today. Unlike today, the employee may also choose a different health plan and use the remainder toward other health benefits or receive additional salary.

Independent Benefits Consultant

The bill also directs DMS to competitively procure an independent benefits consultant (IBC). The IBC must not be or have a financial relationship in any HMO or insurer. Additionally, the IBC must have

[41] The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.
[42] All examples must be hypothetical since the 2018 benefit structure and plan actuarial values cannot be known at this time.

substantial experience in designing and administering benefit plans for large employers and public employers.

The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the state program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2018, and include recommendations for:

- Employer and employee contribution policies.
- Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.
- An education strategy to inform employees on the additional choices available in the state program.

The ongoing duties of the IBC include:

- Providing assessments of trends in benefits and employer sponsored insurance that affect the state program.
- Conducting comprehensive analysis of the state program including available benefits, coverage options, and claims experience.
- Identifying and establishing appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.
- Assist the department with:
  - The submission of any necessary plan revisions for federal review.
  - Ensuring compliance with applicable federal and state regulations.
  - Monitoring the adequacy of funding and reserves for the state self-insured plan.

The IBC will assist DMS in preparing recommendations for any modifications to the state program no later than January 1 of each year which shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.123, F.S., relating to the State Group Insurance Program.
Section 2: Creates s. 110.12303, F.S., relating to the State Group Insurance Program; additional benefits; price transparency cost savings program; reporting.
Section 3: Creates s. 110.12304, F.S., relating to Independent Benefits Consultant.
Section 4: Creates an unnumbered section of law authorizing the Department of Management Services to determine and recommend premiums for employees in the state group insurance plan for the 2017 plan year, submit the proposed premium rates to the Legislative Budget Commission for approval, and providing for application of the premium rates in the 2016-17 General Appropriations Act if the Legislative Budget Commission does not approve the proposed premium rates.
Section 5: Appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds and authorizes 2 full-time equivalent positions and 120,000 of associated salary rate for the 2015-2016 fiscal year to implement the act.
Section 6: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide additional opportunities for private companies to contract to provide services to the state and its employees.

D. FISCAL COMMENTS:

The bill appropriates $507,546 in nonrecurring trust funds and $151,216 in recurring trust funds and 2 FTEs to DMS to implement the administrative provisions of the bill. The positions and recurring funds are provided primarily for the implementation and continued administration of the price transparency pilot project, the administration of certain medical and surgical services provided for in the bill, and the implementation of communication and education components of the bill. The nonrecurring funds are provided to procure consulting services, conduct actuarial analysis, provide procurement support, assist in the development of the premium tiers and the reference pricing pilot project, and assist in the development of communication and education tools to provide employees with the means to make well-informed and educated choices.

The provision requiring DMS to determine and propose employee premium rates that reflect the actuarial benefit difference between the HMO, PPO and HDHPs for plan year 2017, if implemented, will be cost neutral to the state. Employees will generally have a choice between richer benefits and lower premiums.

DMS also indicated that the fiscal impact of the development of the tiered premium structure in plan year 2019 is indeterminate. The cost or savings to the state will be dependent on the specifics of the premium and cost-sharing arrangement ultimately established by the Legislature in implementing the tiered structure. The tiers and premium structure can be designed to be cost-neutral to the state.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DMS has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the state group insurance program;
3 amending s. 110.123, F.S.; revising applicability of
4 certain definitions; defining the term "plan year";
5 authorizing the program to include additional
6 benefits; authorizing an employee to use a specified
7 portion of the state's contribution to purchase
8 additional program benefits and supplemental benefits
9 under certain circumstances; providing for the program
10 to offer health plans in specified benefit levels;
11 requiring the Department of Management Services to
12 develop a plan for implementation of the benefit
13 levels; providing reporting requirements; providing
14 for expiration of the implementation plan; creating s.
15 110.12303, F.S.; authorizing additional benefits to be
16 included in the program; requiring the department to
17 contract with at least one entity that provides
18 comprehensive pricing and inclusive services for
19 surgery and other medical procedures; providing
20 contract and reporting requirements; requiring the
21 department to contract with an entity to provide
22 enrollees with online information on health care
23 services and providers; providing contract and
24 reporting requirements; creating s. 110.12304, F.S.;
25 directing the department to contract with an
26 independent benefits consultant; providing

27 qualifications and duties of the independent benefits
28 consultant; providing reporting requirements;
29 providing that the department shall determine and
30 recommend premiums for enrollees for the 2017 plan
31 year; providing requirements for the determination of
32 premiums; requiring the department to submit premium
33 rates to the Legislative Budget Commission by a
34 specified date for review and approval; requiring
35 premium rates to be consistent with the total budgeted
36 amount for the program in the General Appropriations
37 Act for the 2016-2017 fiscal year; providing an
38 appropriation and authorizing positions; providing an
39 effective date.
40
41 Be It Enacted by the Legislature of the State of Florida:
42
43 Section 1. Subsection (2) and paragraphs (b), (f), (h),
44 and (j) of subsection (3) of section 110.123, Florida Statutes,
45 are amended, and paragraph (k) is added to subsection (3) of
46 that section, to read:
47 110.123 State group insurance program.—
48 (2) DEFINITIONS.—As used in ss. 110.123-110.1239 ~~this~~
49 ~~section~~, the term:
50 (a) "Department" means the Department of Management
51 Services.
52 (b) "Enrollee" means all state officers and employees,

53 retired state officers and employees, surviving spouses of
54 deceased state officers and employees, and terminated employees
55 or individuals with continuation coverage who are enrolled in an
56 insurance plan offered by the state group insurance program.
57 "Enrollee" includes all state university officers and employees,
58 retired state university officers and employees, surviving
59 spouses of deceased state university officers and employees, and
60 terminated state university employees or individuals with
61 continuation coverage who are enrolled in an insurance plan
62 offered by the state group insurance program.
63 (c) "Full-time state employees" means employees of all
64 branches or agencies of state government holding salaried
65 positions who are paid by state warrant or from agency funds and
66 who work or are expected to work an average of at least 30 or
67 more hours per week; employees paid from regular salary
68 appropriations for 8 months' employment, including university
69 personnel on academic contracts; and employees paid from other-
70 personal-services (OPS) funds as described in subparagraphs 1.
71 and 2. The term includes all full-time employees of the state
72 universities. The term does not include seasonal workers who are
73 paid from OPS funds.
74 1. For persons hired before April 1, 2013, the term
75 includes any person paid from OPS funds who:
76 a. Has worked an average of at least 30 hours or more per
77 week during the initial measurement period from April 1, 2013,
78 through September 30, 2013; or

79 b. Has worked an average of at least 30 hours or more per
80 week during a subsequent measurement period.
81 2. For persons hired after April 1, 2013, the term
82 includes any person paid from OPS funds who:
83 a. Is reasonably expected to work an average of at least
84 30 hours or more per week; or
85 b. Has worked an average of at least 30 hours or more per
86 week during the person's measurement period.
87 (d) "Health maintenance organization" or "HMO" means an
88 entity certified under part I of chapter 641.
89 (e) "Health plan member" means any person participating in
90 a state group health insurance plan, a TRICARE supplemental
91 insurance plan, or a health maintenance organization plan under
92 the state group insurance program, including enrollees and
93 covered dependents thereof.
94 (f) "Part-time state employee" means an employee of any
95 branch or agency of state government paid by state warrant from
96 salary appropriations or from agency funds, and who is employed
97 for less than an average of 30 hours per week or, if on academic
98 contract or seasonal or other type of employment which is less
99 than year-round, is employed for less than 8 months during any
100 12-month period, but does not include a person paid from other-
101 personal-services (OPS) funds. The term includes all part-time
102 employees of the state universities.
103 (g) "Plan year" means a calendar year.
104 (h) ~~(g)~~ "Retired state officer or employee" or "retiree"

105 means any state or state university officer or employee who
106 retires under a state retirement system or a state optional
107 annuity or retirement program or is placed on disability
108 retirement, and who was insured under the state group insurance
109 program at the time of retirement, and who begins receiving
110 retirement benefits immediately after retirement from state or
111 state university office or employment. The term also includes
112 any state officer or state employee who retires under the
113 Florida Retirement System Investment Plan established under part
114 II of chapter 121 if he or she:
115 1. Meets the age and service requirements to qualify for
116 normal retirement as set forth in s. 121.021(29); or
117 2. Has attained the age specified by s. 72(t)(2)(A)(i) of
118 the Internal Revenue Code and has 6 years of creditable service.
119 (i) ~~(h)~~ "State agency" or "agency" means any branch,
120 department, or agency of state government. "State agency" or
121 "agency" includes any state university for purposes of this
122 section only.
123 (j) ~~(i)~~ "Seasonal workers" has the same meaning as provided
124 under 29 C.F.R. s. 500.20(s)(1).
125 (k) ~~(j)~~ "State group health insurance plan or plans" or
126 "state plan or plans" mean the state self-insured health
127 insurance plan or plans offered to state officers and employees,
128 retired state officers and employees, and surviving spouses of
129 deceased state officers and employees pursuant to this section.
130 (l) ~~(k)~~ "State-contracted HMO" means any health maintenance

131 organization under contract with the department to participate
132 in the state group insurance program.
133 (m) ~~(l)~~ "State group insurance program" or "programs" means
134 the package of insurance plans offered to state officers and
135 employees, retired state officers and employees, and surviving
136 spouses of deceased state officers and employees pursuant to
137 this section, including the state group health insurance plan or
138 plans, health maintenance organization plans, TRICARE
139 supplemental insurance plans, and other plans required or
140 authorized by law.
141 (n) ~~(m)~~ "State officer" means any constitutional state
142 officer, any elected state officer paid by state warrant, or any
143 appointed state officer who is commissioned by the Governor and
144 who is paid by state warrant.
145 (o) ~~(n)~~ "Surviving spouse" means the widow or widower of a
146 deceased state officer, full-time state employee, part-time
147 state employee, or retiree if such widow or widower was covered
148 as a dependent under the state group health insurance plan, ~~a~~
149 TRICARE supplemental insurance plan, or a health maintenance
150 organization plan established pursuant to this section at the
151 time of the death of the deceased officer, employee, or retiree.
152 "Surviving spouse" also means any widow or widower who is
153 receiving or eligible to receive a monthly state warrant from a
154 state retirement system as the beneficiary of a state officer,
155 full-time state employee, or retiree who died prior to July 1,
156 1979. For the purposes of this section, any such widow or

157 widower shall cease to be a surviving spouse upon his or her
158 remarriage.
159 (p) ~~(o)~~ "TRICARE supplemental insurance plan" means the
160 Department of Defense Health Insurance Program for eligible
161 members of the uniformed services authorized by 10 U.S.C. s.
162 1097.
163 (3) STATE GROUP INSURANCE PROGRAM.—
164 (b) It is the intent of the Legislature to offer a
165 comprehensive package of health insurance and retirement
166 benefits and a personnel system for state employees which are
167 provided in a cost-efficient and prudent manner, and to allow
168 state employees the option to choose benefit plans which best
169 suit their individual needs. ~~Therefore,~~ The state group
170 insurance program ~~is established which~~ may include the state
171 group health insurance plan or plans, health maintenance
172 organization plans, group life insurance plans, TRICARE
173 supplemental insurance plans, group accidental death and
174 dismemberment plans, ~~and~~ group disability insurance plans, ~~.~~
175 ~~Furthermore, the department is additionally authorized to~~
176 ~~establish and provide as part of the state group insurance~~
177 ~~program any~~ other group insurance plans or coverage choices, and
178 other benefits authorized by law ~~that are consistent with the~~
179 ~~provisions of this section~~.
180 (f) Except as provided for in subparagraph (h)2., the
181 state contribution toward the cost of any plan in the state
182 group insurance program shall be uniform with respect to all

183 state employees in a state collective bargaining unit
184 participating in the same coverage tier in the same plan. This
185 section does not prohibit the development of separate benefit
186 plans for officers and employees exempt from the career service
187 or the development of separate benefit plans for each collective
188 bargaining unit. For the 2019 plan year and thereafter, if the
189 state's contribution is more than the premium cost of the health
190 plan selected by the employee, subject to federal limitation,
191 the employee may elect to have the balance:
192 1. Credited to the employee's flexible spending account;
193 2. Credited to the employee's health savings account;
194 3. Used to purchase additional benefits offered through
195 the state group insurance program; or
196 4. Used to increase the employee's salary.
197 (h)1. A person eligible to participate in the state group
198 insurance program may be authorized by rules adopted by the
199 department, in lieu of participating in the state group health
200 insurance plan, to exercise an option to elect membership in a
201 health maintenance organization plan which is under contract
202 with the state in accordance with criteria established by this
203 section and by said rules. The offer of optional membership in a
204 health maintenance organization plan permitted by this paragraph
205 may be limited or conditioned by rule as may be necessary to
206 meet the requirements of state and federal laws.
207 2. The department shall contract with health maintenance
208 organizations seeking to participate in the state group

209 insurance program through a request for proposal or other
210 procurement process, as developed by the Department of
211 Management Services and determined to be appropriate.
212 a. The department shall establish a schedule of minimum
213 benefits for health maintenance organization coverage, and that
214 schedule shall include: physician services; inpatient and
215 outpatient hospital services; emergency medical services,
216 including out-of-area emergency coverage; diagnostic laboratory
217 and diagnostic and therapeutic radiologic services; mental
218 health, alcohol, and chemical dependency treatment services
219 meeting the minimum requirements of state and federal law;
220 skilled nursing facilities and services; prescription drugs;
221 age-based and gender-based wellness benefits; and other benefits
222 as may be required by the department. Additional services may be
223 provided subject to the contract between the department and the
224 HMO. As used in this paragraph, the term "age-based and gender-
225 based wellness benefits" includes aerobic exercise, education in
226 alcohol and substance abuse prevention, blood cholesterol
227 screening, health risk appraisals, blood pressure screening and
228 education, nutrition education, program planning, safety belt
229 education, smoking cessation, stress management, weight
230 management, and women's health education.
231 b. The department may establish uniform deductibles,
232 copayments, coverage tiers, or coinsurance schedules for all
233 participating HMO plans.
234 c. The department may require detailed information from

235 each health maintenance organization participating in the
236 procurement process, including information pertaining to
237 organizational status, experience in providing prepaid health
238 benefits, accessibility of services, financial stability of the
239 plan, quality of management services, accreditation status,
240 quality of medical services, network access and adequacy,
241 performance measurement, ability to meet the department's
242 reporting requirements, and the actuarial basis of the proposed
243 rates and other data determined by the director to be necessary
244 for the evaluation and selection of health maintenance
245 organization plans and negotiation of appropriate rates for
246 these plans. Upon receipt of proposals by health maintenance
247 organization plans and the evaluation of those proposals, the
248 department may enter into negotiations with all of the plans or
249 a subset of the plans, as the department determines appropriate.
250 Nothing shall preclude the department from negotiating regional
251 or statewide contracts with health maintenance organization
252 plans when this is cost-effective and when the department
253 determines that the plan offers high value to enrollees.
254 d. The department may limit the number of HMOs that it
255 contracts with in each service area based on the nature of the
256 bids the department receives, the number of state employees in
257 the service area, or any unique geographical characteristics of
258 the service area. The department shall establish by rule service
259 areas throughout the state.
260 e. All persons participating in the state group insurance

261 program may be required to contribute towards a total state
262 group health premium that may vary depending upon the plan,
263 coverage level, and coverage tier selected by the enrollee and
264 the level of state contribution authorized by the Legislature.
265 3. The department is authorized to negotiate and to
266 contract with specialty psychiatric hospitals for mental health
267 benefits, on a regional basis, for alcohol, drug abuse, and
268 mental and nervous disorders. The department may establish,
269 subject to the approval of the Legislature pursuant to
270 subsection (5), any such regional plan upon completion of an
271 actuarial study to determine any impact on plan benefits and
272 premiums.
273 4. In addition to contracting pursuant to subparagraph 2.,
274 the department may enter into contract with any HMO to
275 participate in the state group insurance program which:
276 a. Serves greater than 5,000 recipients on a prepaid basis
277 under the Medicaid program;
278 b. Does not currently meet the 25-percent non-
279 Medicare/non-Medicaid enrollment composition requirement
280 established by the Department of Health excluding participants
281 enrolled in the state group insurance program;
282 c. Meets the minimum benefit package and copayments and
283 deductibles contained in sub-subparagraphs 2.a. and b.;
284 d. Is willing to participate in the state group insurance
285 program at a cost of premiums that is not greater than 95
286 percent of the cost of HMO premiums accepted by the department

287 in each service area; and
288 e. Meets the minimum surplus requirements of s. 641.225.
289
290 The department is authorized to contract with HMOs that meet the
291 requirements of sub-subparagraphs a.-d. prior to the open
292 enrollment period for state employees. The department is not
293 required to renew the contract with the HMOs as set forth in
294 this paragraph more than twice. Thereafter, the HMOs shall be
295 eligible to participate in the state group insurance program
296 only through the request for proposal or invitation to negotiate
297 process described in subparagraph 2.
298 5. All enrollees in a state group health insurance plan, a
299 TRICARE supplemental insurance plan, or any health maintenance
300 organization plan have the option of changing to any other
301 health plan that is offered by the state within any open
302 enrollment period designated by the department. Open enrollment
303 shall be held at least once each calendar year.
304 6. When a contract between a treating provider and the
305 state-contracted health maintenance organization is terminated
306 for any reason other than for cause, each party shall allow any
307 enrollee for whom treatment was active to continue coverage and
308 care when medically necessary, through completion of treatment
309 of a condition for which the enrollee was receiving care at the
310 time of the termination, until the enrollee selects another
311 treating provider, or until the next open enrollment period
312 offered, whichever is longer, but no longer than 6 months after

313 termination of the contract. Each party to the terminated
314 contract shall allow an enrollee who has initiated a course of
315 prenatal care, regardless of the trimester in which care was
316 initiated, to continue care and coverage until completion of
317 postpartum care. This does not prevent a provider from refusing
318 to continue to provide care to an enrollee who is abusive,
319 noncompliant, or in arrears in payments for services provided.
320 For care continued under this subparagraph, the program and the
321 provider shall continue to be bound by the terms of the
322 terminated contract. Changes made within 30 days before
323 termination of a contract are effective only if agreed to by
324 both parties.
325 7. Any HMO participating in the state group insurance
326 program shall submit health care utilization and cost data to
327 the department, in such form and in such manner as the
328 department shall require, as a condition of participating in the
329 program. The department shall enter into negotiations with its
330 contracting HMOs to determine the nature and scope of the data
331 submission and the final requirements, format, penalties
332 associated with noncompliance, and timetables for submission.
333 These determinations shall be adopted by rule.
334 8. The department may establish and direct, with respect
335 to collective bargaining issues, a comprehensive package of
336 insurance benefits that may include supplemental health and life
337 coverage, dental care, long-term care, vision care, and other
338 benefits it determines necessary to enable state employees to

339 select from among benefit options that best suit their
340 individual and family needs. Beginning with the 2017 plan year,
341 the package of benefits may also include products and services
342 described in s. 110.12303.
343 a. Based upon a desired benefit package, the department
344 shall issue a request for proposal or invitation to negotiate
345 for ~~health insurance~~ providers interested in participating in
346 the state group insurance program, and the department shall
347 issue a request for proposal or invitation to negotiate for
348 ~~insurance~~ providers interested in participating in the non-
349 health-related components of the state group insurance program.
350 Upon receipt of all proposals, the department may enter into
351 contract negotiations with ~~insurance~~ providers submitting bids
352 or negotiate a specially designed benefit package. Insurance
353 providers offering or providing supplemental coverage as of May
354 30, 1991, which qualify for pretax benefit treatment pursuant to
355 s. 125 of the Internal Revenue Code of 1986, with 5,500 or more
356 state employees currently enrolled may be included by the
357 department in the supplemental insurance benefit plan
358 established by the department without participating in a request
359 for proposal, submitting bids, negotiating contracts, or
360 negotiating a specially designed benefit package. These
361 contracts shall provide state employees with the most cost-
362 effective and comprehensive coverage available; however, except
363 as provided in subparagraph (f)3., no state or agency funds
364 shall be contributed toward the cost of any part of the premium

365 of such supplemental benefit plans. With respect to dental
366 coverage, the division shall include in any solicitation or
367 contract for any state group dental program made after July 1,
368 2001, a comprehensive indemnity dental plan option which offers
369 enrollees a completely unrestricted choice of dentists. If a
370 dental plan is endorsed, or in some manner recognized as the
371 preferred product, such plan shall include a comprehensive
372 indemnity dental plan option which provides enrollees with a
373 completely unrestricted choice of dentists.
374 b. Pursuant to the applicable provisions of s. 110.161,
375 and s. 125 of the Internal Revenue Code of 1986, the department
376 shall enroll in the pretax benefit program those state employees
377 who voluntarily elect coverage in any of the supplemental
378 ~~insurance~~ benefit plans as provided by sub-subparagraph a.
379 c. Nothing herein contained shall be construed to prohibit
380 insurance providers from continuing to provide or offer
381 supplemental benefit coverage to state employees as provided
382 under existing agency plans.
383 (j) For the 2019 plan year and thereafter, health plans
384 shall be offered in the following benefit levels:
385 1. Platinum level, which shall have an actuarial value of
386 at least 90 percent.
387 2. Gold level, which shall have an actuarial value of at
388 least 80 percent.
389 3. Silver level, which shall have an actuarial value of at
390 least 70 percent.

391 4. Bronze level, which shall have an actuarial value of at
392 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
393 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
394 ~~contribution toward the cost of any plan in the state group~~
395 ~~insurance plan is the difference between the overall premium and~~
396 ~~the employee contribution. This subsection expires June 30,~~
397 ~~2012~~.
398 (k) In consultation with the independent benefits
399 consultant described in s. 110.12304, the department shall
400 develop a plan for implementation of the benefit levels
401 described in paragraph (j). The plan shall be submitted to the
402 Governor, the President of the Senate, and the Speaker of the
403 House of Representatives by January 1, 2018, and include
404 recommendations for:
405 1. Employer and employee contribution policies.
406 2. Steps necessary for maintaining or improving total
407 employee compensation levels when the transition is initiated.
408 3. An education strategy to inform employees of the
409 additional choices available in the state group insurance
410 program.
411
412 This paragraph expires July 1, 2018.
413 Section 2. Section 110.12303, Florida Statutes, is created
414 to read:
415 110.12303 State group insurance program; additional
416 benefits; price transparency program; reporting.—Beginning with

417 the 2017 plan year:
418 (1) In addition to the comprehensive package of health
419 insurance and other benefits required or authorized to be
420 included in the state group insurance program, the package of
421 benefits may also include products and services offered by:
422 (a) Prepaid limited health service organizations
423 authorized pursuant to part I of chapter 636.
424 (b) Discount medical plan organizations authorized
425 pursuant to part II of chapter 636.
426 (c) Prepaid health clinics licensed under part II of
427 chapter 641.
428 (d) Licensed health care providers, including hospitals
429 and other health facilities, health care clinics, and health
430 professionals, who sell service contracts and arrangements for a
431 specified amount and type of health services.
432 (e) Provider organizations, including service networks,
433 group practices, professional associations, and other
434 incorporated organizations of providers, who sell service
435 contracts and arrangements for a specified amount and type of
436 health services.
437 (f) Entities that provide specific health services in
438 accordance with applicable state law and sell service contracts
439 and arrangements for a specified amount and type of health
440 services.
441 (g) Entities that provide health services or treatments
442 through a bidding process.

443 (h) Entities that provide health services or treatments
444 through the bundling or aggregating of health services or
445 treatments.
446 (i) Entities that provide other innovative and cost-
447 effective health service delivery methods.
448 (2)(a) The department shall contract with at least one
449 entity that provides comprehensive pricing and inclusive
450 services for surgery and other medical procedures which may be
451 accessed at the option of the enrollee. The contract shall
452 require the entity to:
453 1. Have procedures and evidence-based standards to ensure
454 the inclusion of only high-quality health care providers.
455 2. Provide assistance to the enrollee in accessing and
456 coordinating care.
457 3. Provide cost savings to the state group insurance
458 program to be shared with both the state and the enrollee. Cost
459 savings payable to an enrollee may be:
460 a. Credited to the enrollee's flexible spending account;
461 b. Credited to the enrollee's health savings account;
462 c. Credited to the enrollee's health reimbursement
463 account; or
464 d. Paid as additional health plan reimbursements not
465 exceeding the amount of the employee's out-of-pocket medical
466 expenses.
467 4. Provide an educational campaign for enrollees to learn
468 about the services offered by the entity.

469 (b) On or before January 15 of each year, the department
470 shall report to the Governor, the President of the Senate, and
471 the Speaker of the House of Representatives on the participation
472 level and cost-savings to both the enrollee and the state
473 resulting from the contract or contracts described in this
474 subsection.
475 (3) The department shall contract with an entity that
476 provides enrollees with online information on the cost and
477 quality of health care services and providers, allows an
478 enrollee to shop for health care services and providers, and
479 rewards the enrollee by sharing any savings generated by the
480 enrollee's choice of services or providers. The contract shall
481 require the entity to:
482 (a) Establish an Internet-based, consumer-friendly
483 platform that educates and informs enrollees about the price and
484 quality of health care services and providers, including the
485 average amount paid in each county for health care services and
486 providers. The average amounts paid for such services and
487 providers may be expressed for service bundles, which include
488 all products and services associated with a particular treatment
489 or episode of care, or for separate and distinct products and
490 services.
491 (b) Allow enrollees to shop for health care services and
492 providers using the price and quality information provided on
493 the Internet-based platform.
494 (c) Identify the savings realized to the enrollee and

495 state if the enrollee chooses high-quality, lower-cost health
496 care services or providers, and facilitate a shared savings
497 payment to the enrollee. The amount of shared savings shall be
498 determined by a methodology approved by the department and shall
499 maximize value-based purchasing by enrollees. The amount payable
500 to the enrollee may be:
501 1. Credited to the enrollee's flexible spending account;
502 2. Credited to the enrollee's health savings account;
503 3. Credited to the enrollee's health reimbursement
504 account; or
505 4. Paid as additional health plan reimbursements not
506 exceeding the amount of the enrollee's out-of-pocket medical
507 expenses.
508 (d) On or before January 1 of 2018, 2019, and 2020, the
509 department shall report to the Governor, the President of the
510 Senate, and the Speaker of the House of Representatives on the
511 participation level, amount paid to enrollees, and cost-savings
512 to both the enrollees and the state resulting from the
513 implementation of this subsection.
514 Section 3. Section 110.12304, Florida Statutes, is created
515 to read:
516 110.12304 Independent benefits consultant.—
517 (1) The department shall competitively procure an
518 independent benefits consultant.
519 (2) The independent benefits consultant may not:
520 (a) Be owned or controlled by a health maintenance

521 organization or insurer.
522 (b) Have an ownership interest in a health maintenance
523 organization or insurer.
524 (c) Have a direct or indirect financial interest in a
525 health maintenance organization or insurer.
526 (3) The independent benefits consultant must have
527 substantial experience in consultation and design of employee
528 benefit programs for large employers and public employers,
529 including experience with plans that qualify as cafeteria plans
530 under s. 125 of the Internal Revenue Code of 1986.
531 (4) The independent benefits consultant shall:
532 (a) Provide an ongoing assessment of trends in benefits
533 and employer-sponsored insurance that affect the state group
534 insurance program.
535 (b) Conduct a comprehensive analysis of the state group
536 insurance program, including available benefits, coverage
537 options, and claims experience.
538 (c) Identify and establish appropriate adjustment
539 procedures necessary to respond to any risk segmentation that
540 may occur when increased choices are offered to employees.
541 (d) Assist the department with the submission of any
542 necessary plan revisions for federal review.
543 (e) Assist the department in ensuring compliance with
544 applicable federal and state regulations.
545 (f) Assist the department in monitoring the adequacy of
546 funding and reserves for the state self-insured plan.

547 (g) Assist the department in preparing recommendations for
548 any modifications to the state group insurance program which
549 shall be submitted to the Governor, the President of the Senate,
550 and the Speaker of the House of Representatives by January 1 of
551 each year.
552 Section 4. For the 2017 plan year, the Department of
553 Management Services shall determine and recommend premiums for
554 enrollees that reflect the actual differences in costs to the
555 program for each of the health maintenance organization and the
556 preferred provider organization plan options offered in the
557 state group insurance program for both self-insured and fully
558 insured plans. The premium alternatives for the plan options
559 shall reflect the costs to the program for both medical and
560 prescription drug benefits. By July 1, 2016, the department
561 shall submit the proposed enrollee premium rates for the 2017
562 plan year to the Legislative Budget Commission for review and
563 approval. If the Legislative Budget Commission does not approve
564 the proposed rates, the rates provided in the 2016-2017 General
565 Appropriations Act shall apply. The premium rates for employers
566 shall be the same as those established for the state group
567 insurance program in the General Appropriations Act for the
568 2016-2017 fiscal year.
569 Section 5. (1) For the 2016-2017 fiscal year, the sums of
570 $151,216 in recurring funds and $507,546 in nonrecurring funds
571 are appropriated from the State Employees Health Insurance Trust
572 Fund to the Department of Management Services, and two full-time

573 equivalent positions and associated salary rate of 120,000 are
574 authorized, for the purpose of implementing this act.
575 (2)(a) The recurring funds appropriated in this section
576 shall be allocated to the following specific appropriation
577 categories within the Insurance Benefits Administration Program:
578 $150,528 in Salaries and Benefits and $688 in Special Categories
579 Transfer to Department of Management Services—Human Resources
580 Purchased per Statewide Contract.
581 (b) The nonrecurring funds appropriated in this section
582 shall be allocated to the following specific appropriation
583 categories: $500,000 in Special Categories Contracted Services
584 and $7,546 in Expenses.
585 Section 6. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7095 PCB JDC 16-01 Juror Costs
SPONSOR(S): Judiciary Committee, Metz
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Judiciary Committee	18 Y, 0 N	Aziz	Havlicak
1) Appropriations Committee		McAuliffe	Leznoff

SUMMARY ANALYSIS

Prior to 2008, state general revenue funds were used to pay juror and witness payments, as well as juror meals and lodging. Each clerk of court prepared quarterly estimates of the needed funds for the Office of State Courts Administrator. Based on these estimates, state funding was distributed to each clerk of courts. In 2008, the Legislature amended the law to require the clerk of the courts to pay those costs.

This bill would transfer the costs of juror payments, and juror meals and lodging back to the state. This bill provides that each clerk of court will prepare quarterly estimates of the needed funds for the Justice Administrative Commission and, based on these estimates, state funding will be distributed to each clerk of courts.

The bill provides guidance for paying prorated shares to counties in the event that the appropriation is insufficient.

The estimated cost of juror payments, and juror meals and lodging for Fiscal Year 2016-2017 is $11.7 million. This bill will have an annual negative impact on general revenue funds in that amount. The states' clerk of the courts will see a recurring decrease in expenditures in that amount. The necessary appropriation to the Justice Administrative Commission will be included in the FY 2016-17 House proposed General Appropriation Act.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

In 1998, Florida voters approved Revision 7 to Article V of the State Constitution, which required the state to pay certain costs in the judicial system that had previously been county responsibilities. These changes were effective July 1, 2004. To that end, the Legislature defined the elements of the state courts system and assigned funding responsibilities to the state and local governments. State government began paying additional operational costs such as court appointed counsel. County governments continued to pay for facilities, communications, and security for the court system entities. The constitutional amendment also required the 67 county clerks of court to fund their offices using revenues derived from service charges, court costs, filing fees and fines assessed in civil and criminal proceedings. In 2004, s. 28.35, F.S., was amended to require the clerks to pay the payment of jurors and witnesses and the processing of jurors.[1] In 2008, the statute was amended to clarify that the clerks were responsible for paying for juror meals and lodging as well as juror and witness payments.[2]

Prior to 2008, state general revenue funds were used to pay juror and witness payments, as well as juror meals and lodging. Each clerk of court prepared quarterly estimates of the needed funds for the Office of State Courts Administrator. Based on these estimates, state funding was distributed to each clerk of courts. In 2008, the Legislature amended the law to require the clerk of the courts to pay those costs from filing fees, service charges, court costs and fines.[3]

Section 28.35, F.S., currently authorizes the clerks to pay for juror meals and lodging as well as juror and witness payments from filing fees, service charges, costs and fines. Chapter 40, F.S, provides for the management and operations of the state jury system. The chapter specifies that the clerk of the court is responsible for paying for juror payments and meals and lodging.

Effect of the Bill

This bill would transfer the responsibility for the costs of juror payments, and juror meals and lodging back to the state.

This bill amends s. 28.35, F.S., to remove the authorization of the clerks to pay for juror payments and meals and lodging from filing fees, service charges, costs and fines. The bill amends s. 40.29, F.S., to provide that each clerk of court will prepare quarterly estimates of the needed funds for the Justice Administrative Commission and, based on these estimates, state funding will be distributed to each clerk of courts.

The bill also amends s. 40.31, F.S., to provide that if the amount of the appropriation is not sufficient to fund such jury costs during the fiscal year, the Justice Administrative Commission may apportion the funds to the clerks and any deficit would be paid by warrant. Likewise, in a deficit situation the clerks would pay jurors by certificate of the amount of compensation still due. This procedure mirrors current law in respect to witness payments. Sections 40.24, 40.32, 40.33, and 40.34, F.S., are amended to conform to the provisions of the bill.

B. SECTION DIRECTORY:

Section 1. Amends s. 28.35, F.S., relating to the Clerks of Court Operations Corporation.

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[1] Ch. 2004-265, Laws of Fla.
[2] Ch. 2008-111, Laws of Fla.
[3] *Id.*

Section 2. Amends s. 40.24, F.S., relating to the clerk's compensation and reimbursement policy.

Section 3. Amends s. 40.29, F.S., relating to payment of due process costs.

Section 4. Amends s. 40.31, F.S., relating to the Justice Administrative Commission.

Section 5. Amends s. 40.32, F.S., relating to payments to jurors and witnesses.

Section 6. Amends s. 40.33, F.S., relating to deficiency of funds for payment.

Section 7. Amends s. 40.34, F.S., relating to clerk's payroll.

Section 8. Provides and effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

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

2. Expenditures:

   The estimated cost of juror payments, and juror meals and lodging for Fiscal Year 2016-2017 is $11.7 million. This bill will have an annual negative impact on general revenue funds in that amount. The necessary appropriation to the Justice Administrative Commission will be included in the FY 2016-17 House proposed General Appropriation Act.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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

2. Expenditures:

   The estimated cost of juror payments, and juror meals and lodging for Fiscal Year 2016-2017 is $11.7 million. The states' clerk of the courts will see a recurring decrease in expenditures in that amount.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

1 A bill to be entitled
2 An act relating to juror costs; amending s. 28.35,
3 F.S.; revising the list of court-related functions
4 that clerks may fund from filing fees, service
5 charges, costs, and fines; amending s. 40.24, F.S.;
6 conforming provisions to changes made by the act;
7 amending s. 40.29, F.S.; requiring the clerk to
8 forward quarterly estimates on certain jury-related
9 costs to the Justice Administrative Commission;
10 revising procedures governing the payment of certain
11 costs; amending s. 40.31, F.S.; authorizing the
12 commission to apportion funds for specified jury-
13 related costs in certain circumstances; providing for
14 issuance to jurors of certificates for the amount of
15 compensation still due in certain circumstances;
16 amending s. 40.32, F.S.; conforming provisions to
17 changes made by the act; amending s. 40.33, F.S.;
18 authorizing the clerk to make requests to the
19 commission for additional funds to pay certain costs
20 in the event of a deficiency; amending s. 40.34, F.S.;
21 requiring the clerk to provide for payroll in
22 triplicate for the payment of jurors; requiring the
23 clerk to forward a specified number of copies of juror
24 payrolls to the commission by a specified date;
25 requiring the commission to audit such payrolls;
26 providing an effective date.

27
28 Be It Enacted by the Legislature of the State of Florida:
29
30 Section 1. Paragraph (a) of subsection (3) of section
31 28.35, Florida Statutes, is amended to read:
32 28.35 Florida Clerks of Court Operations Corporation.—
33 (3)(a) The list of court-related functions that clerks may
34 fund from filing fees, service charges, costs, and fines is
35 limited to those functions expressly authorized by law or court
36 rule. Those functions include the following: case maintenance;
37 records management; court preparation and attendance; processing
38 the assignment, reopening, and reassignment of cases; processing
39 of appeals; collection and distribution of fines, fees, service
40 charges, and court costs; processing of bond forfeiture
41 payments; ~~payment of jurors and witnesses; payment of expenses~~
42 ~~for meals or lodging provided to jurors;~~ data collection and
43 reporting; processing of jurors; determinations of indigent
44 status; and paying reasonable administrative support costs to
45 enable the clerk of the court to carry out these court-related
46 functions.
47 Section 2. Subsections (3), (4), and (5) of section 40.24,
48 Florida Statutes, are amended to read:
49 40.24 Compensation and reimbursement policy.—
50 (3)(a) Jurors who are regularly employed and who continue
51 to receive regular wages while serving as a juror are not
52 entitled to receive compensation from the state ~~clerk of the~~

53 ~~circuit court~~ for the first 3 days of juror service.
54 (b) Jurors who are not regularly employed or who do not
55 continue to receive regular wages while serving as a juror are
56 entitled to receive $15 per day for the first 3 days of juror
57 service.
58 (4) Each juror who serves more than 3 days is entitled to
59 be paid by the state ~~clerk of the circuit court~~ for the fourth
60 day of service and each day thereafter at the rate of $30 per
61 day of service.
62 (5) Jurors are not entitled to additional reimbursement by
63 the state ~~clerk of the circuit court~~ for travel or other out-of-
64 pocket expenses.
65 Section 3. Section 40.29, Florida Statutes, is amended to
66 read:
67 40.29 Payment of due-process costs.—
68 (1)(a) Each clerk of the circuit court, on behalf of the
69 state attorney, private court-appointed counsel, the public
70 defender, and the criminal conflict and civil regional counsel,
71 shall forward to the Justice Administrative Commission, by
72 county, a quarterly estimate of funds necessary to pay for
73 ordinary witnesses, including, but not limited to, witnesses in
74 civil traffic cases and witnesses of the state attorney, the
75 public defender, criminal conflict and civil regional counsel,
76 private court-appointed counsel, and persons determined to be
77 indigent for costs. Each quarter of the state fiscal year, the
78 commission, based upon the estimates, shall advance funds to

79 each clerk to pay for these ordinary witnesses from state funds
80 specifically appropriated for the payment of ordinary witnesses.
81 (b) Each clerk of the circuit court shall forward to the
82 Justice Administrative Commission a quarterly estimate of funds
83 necessary to pay compensation to jurors and for meals or lodging
84 provided to jurors.
85 (2) Upon receipt of an estimate pursuant to subsection
86 (1), the Justice Administrative Commission shall endorse the
87 amount deemed necessary for payment by the clerk of the court
88 during the quarterly fiscal period and shall submit a request
89 for payment to the Chief Financial Officer.
90 (3) Upon receipt of the funds from the Chief Financial
91 Officer, the clerk of the court shall pay all invoices approved
92 and submitted by the state attorney, the public defender, the
93 clerk of the court, criminal conflict and civil regional
94 counsel, and private court-appointed counsel for the items
95 enumerated in subsection (1).
96 (4) After review for compliance with applicable rates and
97 requirements, the Justice Administrative Commission shall pay
98 all due process service related invoices, except those
99 enumerated in subsection (1), approved and submitted by the
100 state attorney, the public defender, the clerk of the court,
101 criminal conflict and civil regional counsel, or private court-
102 appointed counsel in accordance with the applicable requirements
103 of ss. 29.005, 29.006, and 29.007.
104 Section 4. Section 40.31, Florida Statutes, is amended to

105 read:
106 40.31 Justice Administrative Commission; apportionment of
107 funds; insufficient appropriations ~~may apportion appropriation~~.
108 (1) If the Justice Administrative Commission has reason to
109 believe that the amount appropriated by the Legislature is
110 insufficient to meet the expenses of witnesses during the
111 remaining part of the state fiscal year, the commission may
112 apportion the money in the treasury for that purpose among the
113 several counties, basing such apportionment upon the amount
114 expended for the payment of witnesses in each county during the
115 prior fiscal year. In such case, each county shall be paid by
116 warrant, issued by the Chief Financial Officer, only the amount
117 so apportioned to each county, and, when the amount so
118 apportioned is insufficient to pay in full all the witnesses
119 during a quarterly fiscal period, the clerk of the court shall
120 apportion the money received pro rata among the witnesses
121 entitled to pay and shall give to each witness a certificate of
122 the amount of compensation still due, which certificate shall be
123 held by the commission as other demands against the state.
124 (2) If the Justice Administrative Commission has reason to
125 believe that the amount appropriated by the Legislature is
126 insufficient to meet expenses relating to compensation of jurors
127 and meals and lodging provided to jurors during the remaining
128 part of the state fiscal year, the commission may apportion the
129 money in the treasury for those purposes among the several
130 counties, basing such apportionment upon the amount expended for

131 such purposes in each county during the prior fiscal year. In
132 such case, each county shall be paid by warrant, issued by the
133 Chief Financial Officer, only the amount so apportioned to each
134 county. When the amount so apportioned is insufficient to pay in
135 full all jury-related expenses described herein during a
136 quarterly fiscal period, the clerk of the court shall pay jurors
137 entitled to pay before reimbursing any other jury-related
138 expenses described herein. If the amount so apportioned is
139 insufficient to pay in full all jurors during a quarterly fiscal
140 period, the clerk of the court shall apportion the money
141 received pro rata among the jurors entitled to pay and shall
142 give to each juror a certificate of the amount of compensation
143 still due, which certificate shall be held by the commission as
144 other demands against the state.
145 Section 5. Section 40.32, Florida Statutes, is amended to
146 read:
147 40.32 Clerks to disburse money; payments to jurors and
148 witnesses.—
149 (1) All moneys drawn from the treasury under ~~the~~
150 ~~provisions of~~ this chapter by the clerk of the court shall be
151 disbursed by the clerk of the court as far as needed in payment
152 of jurors and witnesses, except for expert witnesses paid under
153 a contract or other professional services agreement pursuant to
154 ss. 29.004, 29.005, 29.006, and 29.007, for the legal
155 compensation for service during the quarterly fiscal period for
156 which the moneys were drawn and for no other purposes.

157 ~~(2) The payment of jurors and the payment of expenses for~~
158 ~~meals and lodging for jurors under the provisions of this~~
159 ~~chapter are court-related functions that the clerk of the court~~
160 ~~shall fund from filing fees, service charges, court costs, and~~
161 ~~fines.~~
162 (2)~~(3)~~ Jurors and witnesses shall be paid by the clerk of
163 the court in cash, by check, or by warrant within 20 days after
164 completion of jury service or completion of service as a
165 witness.
166 (a) If the clerk of the court pays a juror or witness by
167 cash, the juror or witness shall sign the payroll in the
168 presence of the clerk, a deputy clerk, or some other person
169 designated by the clerk.
170 (b) If the clerk pays a juror or witness by warrant, he or
171 she shall endorse on the payroll opposite the juror's or
172 witness's name the words "Paid by warrant," giving the number
173 and date of the warrant.
174 Section 6. Section 40.33, Florida Statutes, is amended to
175 read:
176 40.33 Deficiency.—If the funds required for payment of the
177 items enumerated in s. 40.29(1) in any county during a quarterly
178 fiscal period exceeds the amount of the funds provided pursuant
179 to s. 40.29(3), the state attorney, public defender, clerk of
180 the circuit court, or criminal conflict and civil regional
181 counsel, as applicable, shall make a further request upon the
182 Justice Administrative Commission for the items enumerated in s.

183 40.29(1) for the amount necessary to allow for full payment.
184 Section 7. Section 40.34, Florida Statutes, is amended to
185 read:
186 40.34 Clerks to make triplicate payroll.—
187 (1) The clerk of the court shall make out a payroll in
188 triplicate for the payment of jurors and witnesses, which
189 payroll shall contain:
190 (a) The name of each juror and witness entitled to be paid
191 with state funds;
192 (b) The number of days for which the jurors and witnesses
193 are entitled to be paid;
194 (c) The number of miles traveled by each; and
195 (d) The total compensation each juror and witness is
196 entitled to receive.
197 (2) The form of such payroll shall be prescribed by the
198 Chief Financial Officer.
199 (3) Compensation paid a juror or witness shall be attested
200 as provided in s. 40.32. The payroll shall be approved by the
201 signature of the clerk, or his or her deputy, except for the
202 payroll as to witnesses appearing before the state attorney,
203 which payroll shall be approved by the signature of the state
204 attorney or an assistant state attorney.
205 (4) The clerks of the courts shall forward two copies of
206 such payrolls to the Justice Administrative Commission, within 2
207 weeks after the last day of the quarterly fiscal period, and the
208 commission shall audit such payrolls.

209 Section 8. This act shall take effect July 1, 2016.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Appropriations Committee
2 Representative Metz offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Paragraph (a) of subsection (3) of section 28.35,
7 Florida Statutes, is amended to read:
8 28.35 Florida Clerks of Court Operations Corporation.—
9 (3)(a) The list of court-related functions that clerks may
10 fund from filing fees, service charges, costs, and fines is
11 limited to those functions expressly authorized by law or court
12 rule. Those functions include the following: case maintenance;
13 records management; court preparation and attendance; processing
14 the assignment, reopening, and reassignment of cases; processing
15 of appeals; collection and distribution of fines, fees, service
16 charges, and court costs; processing of bond forfeiture
17 payments; ~~payment of jurors and witnesses; payment of expenses~~

18 ~~for meals or lodging provided to jurors;~~ data collection and
19 reporting; ~~processing of jurors;~~ determinations of indigent
20 status; and paying reasonable administrative support costs to
21 enable the clerk of the court to carry out these court-related
22 functions.
23 Section 2. Subsections (3), (4), and (5) of section 40.24,
24 Florida Statutes, are amended to read:
25 40.24 Compensation and reimbursement policy.—
26 (3)(a) Jurors who are regularly employed and who continue
27 to receive regular wages while serving as a juror are not
28 entitled to receive compensation from the state ~~clerk of the~~
29 ~~circuit court~~ for the first 3 days of juror service.
30 (b) Jurors who are not regularly employed or who do not
31 continue to receive regular wages while serving as a juror are
32 entitled to receive $15 per day for the first 3 days of juror
33 service.
34 (4) Each juror who serves more than 3 days is entitled to
35 be paid by the state ~~clerk of the circuit court~~ for the fourth
36 day of service and each day thereafter at the rate of $30 per
37 day of service.
38 (5) Jurors are not entitled to additional reimbursement by
39 the state ~~clerk of the circuit court~~ for travel or other out-of-
40 pocket expenses.
41 Section 3. Section 40.29, Florida Statutes, is amended to
42 read:
43 40.29 Payment of due-process costs.—

44 (1)(a) Each clerk of the circuit court, on behalf of the
45 state attorney, private court-appointed counsel, the public
46 defender, and the criminal conflict and civil regional counsel,
47 shall forward to the Justice Administrative Commission, by
48 county, a quarterly estimate of funds necessary to pay for
49 ordinary witnesses, including, but not limited to, witnesses in
50 civil traffic cases and witnesses of the state attorney, the
51 public defender, criminal conflict and civil regional counsel,
52 private court-appointed counsel, and persons determined to be
53 indigent for costs. Each quarter of the state fiscal year, the
54 commission, based upon the estimates, shall advance funds to
55 each clerk to pay for these ordinary witnesses from state funds
56 specifically appropriated for the payment of ordinary witnesses.
57 (b) Each clerk of the circuit court shall forward to the
58 Justice Administrative Commission a quarterly estimate of funds
59 necessary to pay compensation to jurors and for meals or lodging
60 provided to jurors. The Clerks of Court Operations Corporation
61 shall forward to the Justice Administrative Commission a
62 quarterly estimate of jury related personnel costs necessary to
63 pay each clerk of the circuit court personnel costs related to
64 jury management.
65 (2) Upon receipt of an estimate pursuant to subsection
66 (1), the Justice Administrative Commission shall endorse the
67 amount deemed necessary for payment by the clerk of the court
68 during the quarterly fiscal period and shall submit a request
69 for payment to the Chief Financial Officer.

70 (3) Upon receipt of the funds from the Chief Financial
71 Officer, the clerk of the court shall pay all invoices approved
72 and submitted by the state attorney, the public defender, the
73 clerk of the court, criminal conflict and civil regional
74 counsel, and private court-appointed counsel for the items
75 enumerated in subsection (1).
76 (4) After review for compliance with applicable rates and
77 requirements, the Justice Administrative Commission shall pay
78 all due process service related invoices, except those
79 enumerated in subsection (1), approved and submitted by the
80 state attorney, the public defender, the clerk of the court,
81 criminal conflict and civil regional counsel, or private court-
82 appointed counsel in accordance with the applicable requirements
83 of ss. 29.005, 29.006, and 29.007.
84 Section 4. Section 40.31, Florida Statutes, is amended to
85 read:
86 40.31 Justice Administrative Commission; apportionment of
87 funds; insufficient appropriations ~~may apportion appropriation.~~
88 (1) If the Justice Administrative Commission has reason to
89 believe that the amount appropriated by the Legislature is
90 insufficient to meet the expenses of witnesses during the
91 remaining part of the state fiscal year, the commission may
92 apportion the money in the treasury for that purpose among the
93 several counties, basing such apportionment upon the amount
94 expended for the payment of witnesses in each county during the
95 prior fiscal year. In such case, each county shall be paid by

96 warrant, issued by the Chief Financial Officer, only the amount
97 so apportioned to each county, and, when the amount so
98 apportioned is insufficient to pay in full all the witnesses
99 during a quarterly fiscal period, the clerk of the court shall
100 apportion the money received pro rata among the witnesses
101 entitled to pay and shall give to each witness a certificate of
102 the amount of compensation still due, which certificate shall be
103 held by the commission as other demands against the state.
104 (2) If the Justice Administrative Commission has reason to
105 believe that the amount appropriated by the Legislature is
106 insufficient to meet jury related personnel costs and expenses
107 relating to compensation of jurors and meals and lodging
108 provided to jurors during the remaining part of the state fiscal
109 year, the commission may apportion the money in the treasury for
110 those purposes among the several counties, basing such
111 apportionment upon the amount expended for such purposes in each
112 county during the prior fiscal year. In such case, each county
113 shall be paid by warrant, issued by the Chief Financial Officer,
114 only the amount so apportioned to each county. When the amount
115 so apportioned is insufficient to pay in full all jury related
116 personnel costs and jury-related expenses described herein
117 during a quarterly fiscal period, the clerk of the court shall
118 pay jurors entitled to pay before reimbursing any other jury-
119 related expenses described herein. If the amount so apportioned
120 is insufficient to pay in full all jurors during a quarterly
121 fiscal period, the clerk of the court shall apportion the money

122 received pro rata among the jurors entitled to pay and shall
123 give to each juror a certificate of the amount of compensation
124 still due, which certificate shall be held by the commission as
125 other demands against the state. If the amount so apportioned is
126 insufficient to pay in full all jury related personnel costs
127 during a quarterly fiscal period, the clerk of the court shall
128 apportion the money received pro rata among the counties
129 entitled and shall give to each county a certificate of the
130 amount of compensation still due, which certificate shall be
131 held by the commission as other demands against the state.
132 Section 5. Section 40.32, Florida Statutes, is amended to
133 read:
134 40.32 Clerks to disburse money; payments to jurors and
135 witnesses.—
136 (1) All moneys drawn from the treasury under ~~the~~
137 ~~provisions of~~ this chapter by the clerk of the court shall be
138 disbursed by the clerk of the court as far as needed in payment
139 of jurors and witnesses, except for expert witnesses paid under
140 a contract or other professional services agreement pursuant to
141 ss. 29.004, 29.005, 29.006, and 29.007, for the legal
142 compensation for service during the quarterly fiscal period for
143 which the moneys were drawn and for no other purposes.
144 ~~(2) The payment of jurors and the payment of expenses for~~
145 ~~meals and lodging for jurors under the provisions of this~~
146 ~~chapter are court-related functions that the clerk of the court~~
147 ~~shall fund from filing fees, service charges, court costs, and~~

148 ~~fines.~~
149 (2) ~~(3)~~ Jurors and witnesses shall be paid by the clerk of
150 the court in cash, by check, or by warrant within 20 days after
151 completion of jury service or completion of service as a
152 witness.
153 (a) If the clerk of the court pays a juror or witness by
154 cash, the juror or witness shall sign the payroll in the
155 presence of the clerk, a deputy clerk, or some other person
156 designated by the clerk.
157 (b) If the clerk pays a juror or witness by warrant, he or
158 she shall endorse on the payroll opposite the juror's or
159 witness's name the words "Paid by warrant," giving the number
160 and date of the warrant.
161 Section 6. Section 40.33, Florida Statutes, is amended to
162 read:
163 40.33 Deficiency.—If the funds required for payment of the
164 items enumerated in s. 40.29(1) in any county during a quarterly
165 fiscal period exceeds the amount of the funds provided pursuant
166 to s. 40.29(3), the state attorney, public defender, clerk of
167 the circuit court, or criminal conflict and civil regional
168 counsel, as applicable, shall make a further request upon the
169 Justice Administrative Commission for the items enumerated in s.
170 40.29(1) for the amount necessary to allow for full payment.
171 Section 7. Section 40.34, Florida Statutes, is amended to
172 read:
173 40.34 Clerks to make triplicate payroll.—

174 (1) The clerk of the court shall make out a payroll in
175 triplicate for the payment of jurors and witnesses, which
176 payroll shall contain:
177 (a) The name of each juror and witness entitled to be paid
178 with state funds;
179 (b) The number of days for which the jurors and witnesses
180 are entitled to be paid;
181 (c) The number of miles traveled by each; and
182 (d) The total compensation each juror and witness is
183 entitled to receive.
184 (2) The form of such payroll shall be prescribed by the
185 Chief Financial Officer.
186 (3) Compensation paid a juror or witness shall be attested
187 as provided in s. 40.32. The payroll shall be approved by the
188 signature of the clerk, or his or her deputy, except for the
189 payroll as to witnesses appearing before the state attorney,
190 which payroll shall be approved by the signature of the state
191 attorney or an assistant state attorney.
192 (4) The clerks of the courts shall forward two copies of
193 such payrolls to the Justice Administrative Commission, within 2
194 weeks after the last day of the quarterly fiscal period, and the
195 commission shall audit such payrolls.
196 Section 8. This act shall take effect July 1, 2016.
197
198 ----------
199 **T I T L E A M E N D M E N T**

200 Remove everything before the enacting clause and insert:
201 An act relating to juror costs; amending s. 28.35, F.S.;
202 revising the list of court-related functions that clerks may
203 fund from filing fees, service charges, costs, and fines;
204 amending s. 40.24, F.S.; conforming provisions to changes made
205 by the act; amending s. 40.29, F.S.; requiring the clerk and the
206 Florida Clerks of Court Operations Corporation to forward
207 quarterly estimates on certain jury-related costs to the Justice
208 Administrative Commission; revising procedures governing the
209 payment of certain costs; amending s. 40.31, F.S.; authorizing
210 the commission to apportion funds for specified jury-related
211 costs in certain circumstances; providing for issuance to jurors
212 and counties of certificates for the amount of compensation
213 still due in certain circumstances; amending s. 40.32, F.S.;
214 conforming provisions to changes made by the act; amending s.
215 40.33, F.S.; authorizing the clerk to make requests to the
216 commission for additional funds to pay certain costs in the
217 event of a deficiency; amending s. 40.34, F.S.; requiring the
218 clerk to provide for payroll in triplicate for the payment of
219 jurors; requiring the clerk to forward a specified number of
220 copies of juror payrolls to the commission by a specified date;
221 requiring the commission to audit such payrolls; providing an
222 effective date.
223

Appropriations Committee

Tuesday, February 9, 2016
3:00 PM – 6:00 PM
212 Knott Building

Addendum A

Meeting Packet

Steve Crisafulli
Speaker

Richard Corcoran
Chair

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Appropriations Committee
2 Representative Trujillo offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Paragraph (d) is added to subsection (5) of
7 section 395.003, Florida Statutes, to read:
8 395.003 Licensure; denial, suspension, and revocation.—
9 (5)
10 (d) A hospital, ambulatory surgical center, specialty
11 hospital, or urgent care center shall comply with ss. 627.64194
12 and 641.513 as a condition of licensure.
13 Section 2. Subsection (13) is added to section 395.301,
14 Florida Statutes, to read:
15 395.301 Itemized patient bill; form and content prescribed
16 by the agency; patient admission status notification.—
17 (13) A hospital shall post on its website:

18 (a) The names and hyperlinks for direct access to the
19 websites of all health insurers and health maintenance
20 organizations for which the hospital contracts as a network
21 provider or participating provider.
22 (b) A statement that:
23 1. Services provided in the hospital by health care
24 practitioners may not be included in the hospital's charges;
25 2. Health care practitioners who provide services in the
26 hospital may or may not participate in the same health insurance
27 plans as the hospital;
28 3. Prospective patients should contact the health care
29 practitioner arranging for the services to determine the health
30 care plans in which the health care practitioner participates.
31 (c) As applicable, the names, mailing addresses, and
32 telephone numbers of the health care practitioners and practice
33 groups that the hospital has contracted with to provide services
34 in the hospital and instructions on how to contact these health
35 care practitioners and practice groups to determine the health
36 insurers and health maintenance organizations for which the
37 hospital contracts as a network provider or participating
38 provider.
39 Section 3. Paragraph (h) is added to subsection (2) of
40 section 408.7057, Florida Statutes, and subsection (4) of that
41 section is amended, to read:
42 408.7057 Statewide provider and health plan claim dispute
43 resolution program.—

44 (2)
45 (h) Either the contracted or noncontracted provider or the
46 health plan may make an offer to settle the claim dispute when
47 it submits a request for a claim dispute and supporting
48 documentation. The offer to settle the claim dispute must state
49 its total amount, and the party to whom it is directed has 15
50 days to accept the offer once it is received. If the offer to
51 settle the claim dispute is not accepted and the final order is
52 within 10 percent of the offer, the entity that did not accept
53 the offer shall pay the final order amount plus all accrued
54 interest and shall be considered a nonprevailing party for
55 purposes of this section. If the offer to settle the claim
56 dispute is made by the contracted or noncontracted provider, the
57 total amount in the offer to settle the presumed underpayment
58 may not be within 10 percent of the reimbursement amount
59 received by the contracted or noncontracted provider. If the
60 offer to settle the claim dispute is made by the health plan,
61 the offer to settle the presumed overpayment may not be within
62 10 percent of the overpayment amount sought from the contracted
63 or noncontracted provider.
64 (4) Within 30 days after receipt of the recommendation of
65 the resolution organization, the agency shall adopt the
66 recommendation as a final order. The final order is subject to
67 judicial review pursuant to s. 120.68.
68 Section 4. Paragraph (oo) is added to subsection (1) of
69 section 456.072, Florida Statutes, to read:

70 456.072 Grounds for discipline; penalties; enforcement.—
71 (1) The following acts shall constitute grounds for which
72 the disciplinary actions specified in subsection (2) may be
73 taken:
74 (oo) Willfully failing to comply with s. 627.64194 or s.
75 641.513 with such frequency as to indicate a general business
76 practice.
77 Section 5. Paragraph (tt) is added to subsection (1) of
78 section 458.331, Florida Statutes, to read:
79 458.331 Grounds for disciplinary action; action by the
80 board and department.—
81 (1) The following acts constitute grounds for denial of a
82 license or disciplinary action, as specified in s. 456.072(2):
83 (tt) Willfully failing to comply with s. 627.64194 or s.
84 641.513 with such frequency as to indicate a general business
85 practice.
86 Section 6. Paragraph (vv) is added to subsection (1) of
87 section 459.015, Florida Statutes, to read:
88 459.015 Grounds for disciplinary action; action by the
89 board and department.—
90 (1) The following acts constitute grounds for denial of a
91 license or disciplinary action, as specified in s. 456.072(2):
92 (vv) Willfully failing to comply with s. 627.64194 or s.
93 641.513 with such frequency as to indicate a general business
94 practice.

95 Section 7. Paragraph (gg) is added to subsection (1) of
96 section 626.9541, Florida Statutes, to read:
97 626.9541 Unfair methods of competition and unfair or
98 deceptive acts or practices defined.—
99 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
100 ACTS.—The following are defined as unfair methods of competition
101 and unfair or deceptive acts or practices:
102 (gg) Out-of-network reimbursement.—Willfully failing to
103 comply with s. 627.64194 with such frequency as to indicate a
104 general business practice.
105 Section 8. Section 627.64194, Florida Statutes, is created
106 to read:
107 627.64194 Coverage requirements for services provided by
108 nonparticipating providers; payment collection limitations.—
109 (1) As used in this section, the term:
110 (a) "Emergency services" means the services and care to
111 treat an emergency medical condition as defined in s. 641.47(8).
112 (b) "Facility" means a licensed facility as defined in s.
113 395.002(16) and an urgent care center as defined in s.
114 395.002(30).
115 (c) "Insured" means a person who is covered under an
116 individual or group health insurance policy delivered or issued
117 for delivery in this state by an insurer authorized to transact
118 business in this state.
119 (d) "Nonemergency services" means the services and care to
120 treat a condition other than an emergency medical condition.

121 (e) "Nonparticipating provider" means a provider who is
122 not a preferred provider as defined in s. 627.6471 or a provider
123 who is not an exclusive provider as defined in s. 627.6472. A
124 facility licensed under chapter 395 is not a nonparticipating
125 provider. A provider is also considered a nonparticipating
126 provider for the purposes of any emergency physician services
127 performed if:
128 1. The provider is employed by a facility licensed under
129 chapter 395 that has a contract with the insurer to provide
130 emergency services; and
131 2. The provider is not a preferred provider as defined in
132 s. 627.6471 or the provider is not an exclusive provider as
133 defined in s. 627.6472.
134 (f) "Participating provider" means a preferred provider as
135 defined in s. 627.6471 or an exclusive provider as defined in s.
136 627.6472, but does not mean a facility licensed under chapter
137 395.
138 (2) An insurer is solely liable for payment of fees to a
139 nonparticipating provider of covered emergency services provided
140 to an insured in accordance with the coverage terms of the
141 health insurance policy, and such insured is not liable for
142 payment of fees for covered services to a nonparticipating
143 provider of emergency services, other than applicable copayments
144 and deductibles. An insurer must provide coverage for emergency
145 services that:
146 (a) May not require prior authorization.

147 (b) Must be provided regardless of whether the service is
148 furnished by a participating provider or a nonparticipating
149 provider.
150 (c) May impose a coinsurance amount, copayment, or
151 limitation of benefits requirement for a nonparticipating
152 provider only if the same requirement applies to a participating
153 provider.
154
155 The provisions of s. 627.638 apply to this subsection.
156 (3) An insurer is solely liable for payment of fees to a
157 nonparticipating provider of covered nonemergency services
158 provided to an insured in accordance with the coverage terms of
159 the health insurance policy, and such insured is not liable for
160 payment of fees to a nonparticipating provider, other than
161 applicable copayments and deductibles, for covered nonemergency
162 services that are:
163 (a) Provided in a facility that has a contract for the
164 nonemergency services with the insurer which the facility would
165 be otherwise obligated to provide under contract with the
166 insurer; and
167 (b) Provided when the insured does not have the ability
168 and opportunity to choose a participating provider at the
169 facility who is available to treat the insured.
170
171 The provisions of s. 627.638 apply to this subsection.

172 (4) An insurer must reimburse a nonparticipating provider
173 of services under subsections (2) and (3) as specified in s.
174 641.513(5) within the applicable timeframe provided in s.
175 627.6131.
176 (5) A nonparticipating provider of emergency services as
177 provided in subsection (2) or a nonparticipating provider of
178 nonemergency services as provided in subsection (3) may not be
179 reimbursed an amount greater than the amount provided in
180 subsection (4) and may not collect or attempt to collect from
181 the insured, directly or indirectly, any excess amount, other
182 than copayments and deductibles. This section does not prohibit
183 a nonparticipating provider from collecting or attempting to
184 collect from the insured an amount due for the provision of
185 noncovered services.
186 (6) Any dispute with regard to the reimbursement to the
187 nonparticipating provider of emergency or nonemergency services
188 as provided in subsection (4) shall be resolved in a court of
189 competent jurisdiction or through the voluntary dispute
190 resolution process in s. 408.7057.
191 Section 9. Subsection (2) of section 627.6471, Florida
192 Statutes, is amended to read:
193 627.6471 Contracts for reduced rates of payment;
194 limitations; coinsurance and deductibles.—
195 (2) Any insurer issuing a policy of health insurance in
196 this state, which insurance includes coverage for the services
197 of a preferred provider, must provide each policyholder and

198 certificateholder with a current list of preferred providers and
199 must make the list available on its website. The list must
200 include, when applicable and reported, a listing by specialty of
201 the names, addresses, and telephone numbers of all participating
202 providers, including facilities, and, in the case of physicians,
203 must also include board certifications, languages spoken, and
204 any affiliations with participating hospitals. Information
205 posted on the insurer's website must be updated on at least a
206 calendar-month basis with additions or terminations of providers
207 from the insurer's network or reported changes in physicians'
208 hospital affiliations ~~for public inspection during regular~~
209 ~~business hours at the principal office of the insurer within the~~
210 ~~state~~.
211 Section 10. Effective upon this act becoming a law,
212 subsection (7) is added to section 627.6471, Florida Statutes,
213 to read:
214 627.6471 Contracts for reduced rates of payment;
215 limitations; coinsurance and deductibles.—
216 (7) Any policy issued under this section after January 1,
217 2017, must include the following disclosure: "WARNING: LIMITED
218 BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.
219 You should be aware that when you elect to utilize the services
220 of a nonparticipating provider for a covered nonemergency
221 service, benefit payments to the provider are not based upon the
222 amount the provider charges. The basis of the payment will be
223 determined according to your policy's out-of-network

224 reimbursement benefit. Nonparticipating providers may bill
225 insureds for any difference in the amount. YOU MAY BE REQUIRED
226 TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.
227 Participating providers have agreed to accept discounted
228 payments for services with no additional billing to you other
229 than coinsurance and deductible amounts. You may obtain further
230 information about the providers who have contracted with your
231 insurance plan by consulting your insurer's website or
232 contacting your insurer or agent directly."
233 Section 11. Subsection (15) is added to section 627.662,
234 Florida Statutes, to read:
235 627.662 Other provisions applicable.—The following
236 provisions apply to group health insurance, blanket health
237 insurance, and franchise health insurance:
238 (15) Section 627.64194, relating to coverage requirements
239 for services provided by nonparticipating providers and payment
240 collection limitations.
241 Section 12. Except as otherwise expressly provided in this
242 act and except for this section, which shall take effect upon
243 this act becoming a law, this act shall take effect October 1,
244 2016.
245
246 ----------
247 **T I T L E A M E N D M E N T**
248 Remove everything before the enacting clause and insert:
249 A bill to be entitled

250 An relating to out-of-network health insurance
251 coverage; amending s. 395.003, F.S.; requiring
252 hospitals, ambulatory surgical centers, specialty
253 hospitals, and urgent care centers to comply with
254 certain provisions as a condition of licensure;
255 amending s. 395.301, F.S.; requiring a hospital to
256 post on its website certain information regarding its
257 contracts with health insurers, health maintenance
258 organizations, and health care practitioners and
259 practice groups and specified notice to patients and
260 prospective patients; amending s. 408.7057, F.S.;
261 providing a claim dispute resolution process for
262 certain providers and health plans; requiring a final
263 order to be subject to judicial review; amending ss.
264 456.072, 458.331, and 459.015, F.S.; providing
265 additional acts that constitute grounds for denial of
266 a license or disciplinary action, to which penalties
267 apply; amending s. 626.9541, F.S.; specifying an
268 additional unfair method of competition and unfair or
269 deceptive act or practice; creating s. 627.64194,
270 F.S.; defining terms; specifying requirements for
271 coverage provided by an insurer for emergency
272 services; providing that an insurer is solely liable
273 for payment of certain fees to a nonparticipating
274 provider; providing limitations and requirements for
275 reimbursements by an insurer to a nonparticipating

276 provider; providing that certain disputes relating to
277 reimbursement of a nonparticipating provider shall be
278 resolved in a court of competent jurisdiction or
279 through a specified voluntary dispute resolution
280 process; amending s. 627.6471, F.S.; requiring an
281 insurer that issues a policy including coverage for
282 the services of a preferred provider to post on its
283 website certain information about participating
284 providers and physicians; requiring that specified
285 notice be included in policies issued after a
286 specified date which provide coverage for the services
287 of a preferred provider; amending s. 627.662, F.S.;
288 providing applicability of provisions relating to
289 coverage for emergency services and payment collection
290 limitations to group health insurance, blanket health
291 insurance, and franchise health insurance; providing
292 effective dates.