APPROPRIATIONS COMMITTEE

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

Meeting Packet

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

CS/HB 139

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.

[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]

[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.

A bill to be entitled

An act relating to dental care; creating s. 381.4019, F.S.; establishing a joint local and state dental care access account initiative, subject to the availability of funding; authorizing the creation of dental care access accounts; specifying the purpose of the initiative; providing definitions; providing criteria for the selection of dentists for participation in the initiative; providing for the establishment of accounts; limiting the number of new dental care access accounts established per fiscal year; requiring the Department of Health to implement an electronic benefit transfer system; providing for the use of funds deposited in the accounts; authorizing the department to distribute state funds to accounts, subject to legislative appropriation; authorizing the department to accept contributions from local sources for deposit in designated accounts; limiting the number of years that an account may remain open; providing for the immediate closure of accounts under certain circumstances; authorizing the department to transfer state funds remaining in a closed account at a specified time; requiring the department to return unspent funds from local sources; requiring a dentist to repay funds in certain circumstances; authorizing the department to pursue disciplinary enforcement actions and to use other legal means to recover funds; requiring the department to establish by rule application procedures and a process to verify the use of funds withdrawn from a dental care access account; requiring the department to give priority to applications from dentists practicing in certain areas; requiring the Department of Economic Opportunity to rank shortage areas and medically underserved areas; requiring the Department of Health to annually submit a report with certain information to the Governor and the Legislature; requiring rulemaking for the submission of information for such reporting; providing an effective date.

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

Section 1. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental care access accounts.—Subject to the availability of funds, the Legislature establishes a joint local and state dental care access account initiative and authorizes the creation of dental care access accounts to promote economic development by supporting qualified dentists who practice in dental health professional shortage areas or medically underserved areas or who treat a medically underserved population. The Legislature recognizes that maintaining good oral health is integral to overall health status and that the good health of residents of this state is an important contributing factor in economic development. Better health, including better oral health, enables workers to be more productive, reduces the burden of health care costs, and improves the cognitive development of children.

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

(a) "Dental health professional shortage area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Medically underserved area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(d) "Public health program" means a county health department, the Children's Medical Services program, a federally qualified community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program as designated by the department.

(2) The department shall develop and implement a dental care access account initiative to benefit dentists licensed to practice in this state who demonstrate, as required by the department by rule:

(a) Active employment by a public health program located in a dental health professional shortage area or a medically underserved area; or

(b) A commitment to opening a private practice in a dental health professional shortage area or a medically underserved area evidenced by residing in the designated area, maintaining an active Medicaid provider agreement, enrolling in one or more Medicaid managed care plans, expending sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients, and obtaining financial support from the local community in which the dentist is practicing or intending to open a practice.

(3) The department shall establish dental care access accounts as individual benefit accounts for each dentist who satisfies the requirements of subsection (2) and is selected by the department for participation. The department may not establish more than 10 new dental care access accounts per fiscal year. The department shall implement an electronic benefits transfer system that enables each dentist to spend funds from his or her account for the purposes described in subsection (4).

(4) Funds contributed from state and local sources to a dental care access account may be used for one or more of the following purposes:

(a) Repayment of dental school student loans.

(b) Investment in property, facilities, or equipment necessary to establish and operate a dental office consisting of at least two operatories.

(c) Payment of transitional expenses related to the relocation or opening of a dental practice which are specifically approved by the department.

(5) Subject to legislative appropriation, the department shall distribute state funds as an award to each dental care access account. Such awards must be in an amount not more than $100,000 and at least $10,000, except that a state award may not exceed 3 times the amount contributed to an account in the same year from local sources. If a dentist qualifies for a dental care access account under paragraph (2)(a), the dentist's salary and associated employer expenditures constitute a local match and qualify the account for a state award if the salary and associated expenditures do not come from state funds. State funds may not be included in a determination of the amount contributed to an account from local sources.

(6) The department may accept contributions of funds from local sources for deposit in the account of a dentist designated by the donor.

(7) The department shall close an account no later than 5 years after the first deposit of state or local funds into that account or immediately upon the occurrence of any of the following:

(a) Termination of the dentist's employment with a public health program unless, within 30 days after such termination, the dentist opens a private practice in a dental health professional shortage area or medically underserved area.

(b) Termination of the dentist's practice in a designated dental health professional shortage area or medically underserved area.

(c) Termination of the dentist's participation in the Florida Medicaid program.

(d) Participation by the dentist in any fraudulent activity.

(8) Any state funds remaining in a closed account may be awarded and transferred to another account concurrent with the distribution of funds under the next legislative appropriation for the initiative. The department shall return to the donor on a pro rata basis unspent funds from local sources which remain in a closed account.

(9) If the department determines that a dentist has withdrawn account funds after the occurrence of an event specified in subsection (7), has used funds for purposes not authorized in subsection (4), or has not remained eligible for a dental care access account for a minimum of 2 years, the dentist shall repay the funds to his or her account. The department may recover the withdrawn funds through disciplinary enforcement actions and other methods authorized by law.

(10) The department shall establish by rule:

(a) Application procedures for dentists who wish to apply for a dental care access account. An applicant may demonstrate that he or she has expended sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients by documenting contracts for the purchase or lease of a practice location and providing executed obligations for the purchase or other acquisition of at least 30 percent of the value of equipment or supplies necessary to operate a dental practice. The department may limit the number of applicants selected and shall give priority to those applicants practicing in the areas receiving higher rankings pursuant to subsection (11). The department may establish additional criteria for selection which recognize an applicant's active engagement with and commitment to the community providing a local match.

(b) A process to verify that funds withdrawn from a dental care access account have been used solely for the purposes described in subsection (4).

(11) The Department of Economic Opportunity shall rank the dental health professional shortage areas and medically underserved areas of the state based on the extent to which limited access to dental care is impeding the area's economic development, with a higher ranking indicating a greater impediment to development.

(12)(a) By January 1 of each year, beginning in 2018, the department shall issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, which must include:

1. The number of patients served by dentists receiving

funding under this section.

2. The number of Medicaid recipients served by dentists receiving funding under this section.

3. The average number of hours worked and patients served in a week by dentists receiving funding under this section.

4. The number of dentists in each dental health professional shortage area or medically underserved area receiving funding under this section.

5. The amount and source of local matching funds received by the department.

6. The amount of state funds awarded to dentists under this section.

7. A complete accounting of the use of funds, by categories identified by the department, including, but not limited to, loans, supplies, equipment, rental property payments, real property purchases, and salary and wages.

(b) The department shall adopt rules to require dentists to report information to the department which is necessary for the department to fulfill its reporting requirement under this subsection.

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	____	

Committee/Subcommittee hearing bill: Appropriations Committee
Representative Cummings offered the following:

Amendment (with title amendment)

Between lines 202 and 203, insert:

Section 2. For the 2016-2017 fiscal year, 1 full-time equivalent position, with associated salary rate of 46,381 is authorized and the sums of $90,542 in recurring funds and $19,766 in nonrecurring funds to administer the program and $1,000,000 in recurring funds to allocate to dental care access accounts from the General Revenue Fund are hereby appropriated to the Department of Health for the purpose of implementing the requirements of the act.

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

Remove line 39 and insert:

reporting; providing an appropriation; providing an effective 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-sz9DT7TXvXwlLDCoV9tYHvY36G5i73DlRghX6-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

[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.

<u>Miscellaneous Changes</u>

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.

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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.

A bill to be entitled

An act relating to out-of-network health insurance coverage; amending s. 395.003, F.S.; requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; amending s. 395.301, F.S.; requiring a hospital to post on its website certain information regarding its contracts with health insurers, health maintenance organizations, and health care practitioners and practice groups and specified notice to patients and prospective patients; amending s. 456.072, F.S.; adding a ground for discipline of referring health care providers by the Department of Health; creating s. 627.64194, F.S.; defining terms; specifying requirements for coverage provided by an insurer for emergency services; providing that an insurer is solely liable for payment of certain fees to a nonparticipating provider; providing limitations and requirements for reimbursements by an insurer to a nonparticipating provider; authorizing a nonparticipating provider or insurer to initiate arbitration to determine additional reimbursement; requiring the Department of Financial Services to publish a list of approved arbitrators; specifying timeframes and the process for choosing an arbitrator;

providing requirements for the arbitration process, including responsibility for attorney fees and additional costs; amending s. 627.6471, F.S.; requiring an insurer that issues a health insurance policy including coverage for preferred provider services to post certain information about preferred providers, preferred provider facilities, and health care providers in the preferred provider network on its website; requiring a specified notice to be included in such policies; providing an effective date.

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

Section 1. Paragraph (d) is added to subsection (5) of section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(5)

(d) A hospital, ambulatory surgical center, specialty hospital, or urgent care center shall comply with ss. 627.64194 and 641.513 as a condition of licensure.

Section 2. Subsection (13) is added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency; patient admission status notification.—

(13) Each hospital shall post on its website:

(a) The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations with which the hospital contracts as a network provider or participating provider.

(b) A statement that:

1. Services provided in the hospital by health care practitioners may not be included in the hospital's charges.

2. Health care practitioners who provide services in the hospital may or may not participate with the same health insurers and health maintenance organizations with which the hospital contracts.

3. Prospective patients should contact the health care practitioner arranging for the services to determine the health care plans in which the health care practitioner participates.

(c) As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and practice groups under contract with the hospital to provide services in the hospital and instructions on how to contact such practitioners and practice groups to determine the health insurers and health maintenance organizations with which the hospital contracts as a network provider or participating provider.

Section 3. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(oo) Failing to comply with s. 627.64194 or s. 641.513 with such frequency as to constitute a general business practice.

Section 4. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage requirements for services provided by nonparticipating providers.—

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

(a) "Emergency services" means the services and care to treat an emergency medical condition, as defined in s. 395.002. The term "emergency services" includes emergency transportation and ambulance services to the extent permitted by applicable state and federal law.

(b) "Facility" means a licensed facility, as defined in s. 395.002, or an urgent care center, as defined in s. 395.002.

(c) "Nonemergency services" means the services and care to treat a condition other than an emergency medical condition, as defined in s. 395.002.

(d) "Nonparticipating provider" means a provider that is not a preferred provider, as defined in s. 627.6471, or an exclusive provider, as defined in s. 627.6472.

(e) "Participating provider" means a preferred provider, as defined in s. 627.6471, or an exclusive provider, as defined in s. 627.6472.

(2) An insurer is solely liable for payment of fees to a nonparticipating provider of emergency services and an insured is not liable for payment of fees, other than applicable copayments and deductibles, to a nonparticipating provider of emergency services. An insurer must provide coverage for emergency services that:

(a) May not require prior authorization.

(b) Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

(3) An insurer is solely liable for payment of fees to a nonparticipating provider of nonemergency services and an insured is not liable for payment of fees, other than applicable copayments and deductibles, to a nonparticipating provider of nonemergency services that are:

(a) Provided in a facility that has a contract with the insurer.

(b) Provided under circumstances in which the insured does not have the ability and opportunity to choose a participating provider at the facility.

(4) An insurer must reimburse a nonparticipating provider of emergency services or nonemergency services within the applicable timeframe provided in s. 627.6131:

(a) The billed amount;

(b) An amount that is a reasonable reimbursement for the services and care rendered; or

(c) A charge mutually agreed to by the insurer and the nonparticipating provider.

(5) A nonparticipating provider of emergency services or nonemergency services may not be reimbursed an amount greater than that provided in subsection (4) or subsection (6) by the insurer and may not collect or attempt to collect from the patient, directly or indirectly, any excess amount.

(6)(a) If an insured has assigned his or her benefit of payment to the nonparticipating provider, the nonparticipating provider may, within 60 days after receipt of the reimbursement provided in subsection (4), request additional reimbursement by making a final reimbursement offer to the insurer. Within 30 days after receipt of the nonparticipating provider's final reimbursement offer, the insurer shall notify the nonparticipating provider of its final reimbursement offer. The nonparticipating provider may initiate binding arbitration within 30 days after receipt of the insurer's final reimbursement offer by notifying the insurer and the department. The notice of initiation of binding arbitration shall include the final reimbursement offers from the nonparticipating provider and the insurer. The parties may agree to resolve multiple claims for additional reimbursement.

(b) The department shall publish a list of arbitrators that it has approved to provide binding arbitration. Approved arbitrators shall be trained by the American Arbitration Association or the American Health Lawyers Association. The parties must agree and notify the department of their choice of an arbitrator from the list of approved arbitrators within 10 business days after issuance of the notice of initiation of binding arbitration. If the parties cannot reach an agreement, the nonparticipating provider shall, within 15 business days after receiving the notice of initiation of binding arbitration, request from the department the names of five approved arbitrators. The insurer and the nonparticipating provider may each veto two of the arbitrators. The nonparticipating provider shall be the first party to veto two of the arbitrators and, within 5 business days after receiving the names of the five arbitrators, shall notify the insurer and the department of the names of the two arbitrators it has vetoed. After receiving the notice of veto, the insurer shall have 5 business days to notify the nonparticipating provider and the department of the names of the two arbitrators it has vetoed. The arbitrator remaining after both parties have submitted their vetoes shall be the chosen arbitrator.

(c) When making a determination of whether a nonparticipating provider shall receive additional reimbursement pursuant to this subsection, the parties may provide and the arbitrator shall consider documentation of:

1. Individual patient characteristics.

2. The level of training, education, and experience of the nonparticipating provider.

3. The nonparticipating provider's usual and customary charge for similar or comparable services provided out-of-network with respect to any health care plan.

4. A participating provider's contracted rate of payment for similar or comparable services in the same geographic area.

5. The aggregate provider charge, as defined by a public independent database of charges, for similar or comparable services in the same geographic area.

6. A percentage of the Medicare allowable rate for similar or comparable services in the same geographic area.

7. The usual and customary reimbursement by an insurer for similar or comparable services in the same geographic area.

8. The nonparticipating provider's billed charges for the services provided.

9. The circumstances and complexity of the particular case, including the time and location of the service provided.

10. Discounts or rebates applied by the nonparticipating provider to charges for similar or comparable services billed to persons who are uninsured, indigent, or experiencing a financial hardship.

11. Previous arbitration decisions made under this subsection for similar or comparable services provided under similar or comparable circumstances and characteristics.

(d) The arbitration shall consist only of a review of the final reimbursement offer submitted by each party pursuant to paragraph (a) and any documentation submitted pursuant to paragraph (c). The arbitrator's decision shall be one of the two amounts that were submitted as final reimbursement offers pursuant to paragraph (a).

(e) The arbitrator shall render a written decision within 60 days after being named the chosen arbitrator and file the decision with the department. The parties shall be bound by the arbitrator's decision. The cost of arbitration shall be reasonable and shall be equally shared by the parties. Each party is responsible for his or her own attorney fees and additional costs.

Section 5. Subsection (2) of section 627.6471, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

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

(2) Any insurer issuing a policy of health insurance in this state, which insurance includes coverage for the services of a preferred provider, must provide each policyholder and certificateholder with a current list of preferred providers and must make the list available on its website. The list must

include, when applicable and reported, organized by specialty: the names, addresses, and telephone numbers of all preferred providers and, for physicians, their board certifications, languages spoken, and facility affiliations; and the names, addresses, and telephone numbers of all preferred provider facilities. Information posted on the insurer's website must be updated each calendar month and include additions or terminations of preferred providers, preferred provider facilities, and health care providers in the preferred provider network or changes in a health care provider's facility affiliations ~~must make the list available for public inspection during regular business hours at the principal office of the insurer within the state~~.

(7) Each policy issued under this section must include the following disclosure: "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to use the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based on the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance and deductible amounts. You may

obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

Section 6. This act shall take effect October 1, 2016.

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 HAH	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

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[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

A bill to be entitled

An act relating to property prepared for tax-exempt use; creating s. 196.1955, F.S.; consolidating provisions relating to obtaining an ad valorem exemption for property owned by exempt organizations; requiring the owner of an exempt organization to take affirmative steps to demonstrate the property's exempt use; authorizing the property appraiser to serve a notice of tax lien on exempt property that is not in actual exempt use after a specified time; providing that the lien attaches to any property owned by the organization identified in the notice of lien; prohibiting a property appraiser from serving a notice of tax lien on certain property being prepared for use as a house of public worship; defining the terms "charitable use," "affirmative steps," and "public worship"; amending s. 196.196, F.S.; deleting provisions relating to the exemption as it applies to public worship and affordable housing and provisions that have been moved to s. 196.1955, F.S.; amending s. 196.198, F.S.; deleting provisions that have been moved to s. 196.1955, F.S., relating to property owned by an educational institution and used for an educational purpose; providing an effective date.

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

Section 1. Section 196.1955, Florida Statutes, is created to read:

196.1955 Preparing property for educational, literary, scientific, religious, or charitable use.—

(1) Property owned by an exempt entity is used for an exempt purpose if the owner has taken affirmative steps to prepare the property for an exempt educational, literary, scientific, religious, or charitable use and no portion of the property is being used for a nonexempt purpose. The term "charitable use" means, but is not limited to, providing affordable housing to extremely-low-income, very-low-income, low-income, or moderate-income persons and families as defined in s. 420.0004. The term "affirmative steps" means environmental or land use permitting activities, creation of architectural plans or schematic drawings, land clearing or site preparation, construction or renovation activities, or other similar activities that demonstrate a commitment to preparing the property for an exempt use.

(2)(a) If property owned by an organization that has been granted an exemption under this section is transferred for a purpose other than an exempt use or is not in actual exempt use within 5 years after the date the organization is granted an exemption, the property appraiser making such determination may serve upon the organization that received the exemption a notice of intent to record in the public records of the county a notice of tax lien against any property owned by that organization in that county, and such property must be identified in the notice of tax lien. The organization owning such property is subject to the taxes otherwise due as a result of the failure to use the property in an exempt manner plus 15 percent interest per annum.

1. The lien, when filed, attaches to any property identified in the notice of tax lien owned by the organization that received the exemption. If the organization no longer owns property in the county but owns property in any other county in the state, the property appraiser shall record in each such county a notice of tax lien identifying the property owned by the organization in each respective county, which shall become a lien against the identified property.

2. Before such lien may be filed, the organization so notified must be given 30 days to pay the taxes and interest.

3. If an exemption is improperly granted as a result of a clerical mistake or an omission by the property appraiser, the organization improperly receiving the exemption may not be assessed interest.

4. The 5-year limitation specified in this subsection may be extended by the property appraiser if the organization holding the exemption continues to take affirmative steps to develop the property for the purposes specified in this section.

(b) This subsection does not apply to property being prepared for use as a house of public worship. The term "public worship" means religious worship services and activities that are incidental to religious worship services, such as educational activities, parking, recreation, partaking of meals, and fellowship.

Section 2. Subsections (3), (4), and (5) of section 196.196, Florida Statutes, are amended to read:

196.196 Determining whether property is entitled to charitable, religious, scientific, or literary exemption.—

~~(3) Property owned by an exempt organization is used for a religious purpose if the institution has taken affirmative steps to prepare the property for use as a house of public worship. The term "affirmative steps" means environmental or land use permitting activities, creation of architectural plans or schematic drawings, land clearing or site preparation, construction or renovation activities, or other similar activities that demonstrate a commitment of the property to a religious use as a house of public worship. For purposes of this subsection, the term "public worship" means religious worship services and those other activities that are incidental to religious worship services, such as educational activities, parking, recreation, partaking of meals, and fellowship.~~

(3)~~(4)~~ Except as otherwise provided in this section ~~herein~~, property claimed as exempt for literary, scientific, religious, or charitable purposes which is used for profitmaking purposes is ~~shall be~~ subject to ad valorem taxation. Use of property for functions not requiring a business or occupational license conducted by the organization at its primary residence, the revenue of which is used wholly for exempt purposes, is ~~shall~~ not ~~be~~ considered profitmaking ~~profit making~~. In this connection, the playing of bingo on such property is ~~shall~~ not ~~be~~ considered as using such property in such a manner as would impair its exempt status.

~~(5)(a) Property owned by an exempt organization qualified as charitable under s. 501(c)(3) of the Internal Revenue Code is used for a charitable purpose if the organization has taken affirmative steps to prepare the property to provide affordable housing to persons or families that meet the extremely-low-income, very-low-income, low-income, or moderate-income limits, as specified in s. 420.0004. The term "affirmative steps" means environmental or land use permitting activities, creation of architectural plans or schematic drawings, land clearing or site preparation, construction or renovation activities, or other similar activities that demonstrate a commitment of the property to providing affordable housing.~~

~~(b)1. If property owned by an organization granted an exemption under this subsection is transferred for a purpose other than directly providing affordable homeownership or rental housing to persons or families who meet the extremely-low-income, very-low-income, low-income, or moderate-income limits, as specified in s. 420.0004, or is not in actual use to provide such affordable housing within 5 years after the date the organization is granted the exemption, the property appraiser making such determination shall serve upon the organization that~~

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

~~illegally or improperly received the exemption a notice of intent to record in the public records of the county a notice of tax lien against any property owned by that organization in the county, and such property shall be identified in the notice of tax lien. The organization owning such property is subject to the taxes otherwise due and owing as a result of the failure to use the property to provide affordable housing plus 15 percent interest per annum and a penalty of 50 percent of the taxes owed.~~

~~2. Such lien, when filed, attaches to any property identified in the notice of tax lien owned by the organization that illegally or improperly received the exemption. If such organization no longer owns property in the county but owns property in any other county in the state, the property appraiser shall record in each such other county a notice of tax lien identifying the property owned by such organization in such county which shall become a lien against the identified property. Before any such lien may be filed, the organization so notified must be given 30 days to pay the taxes, penalties, and interest.~~

~~3. If an exemption is improperly granted as a result of a clerical mistake or an omission by the property appraiser, the organization improperly receiving the exemption shall not be assessed a penalty or interest.~~

~~4. The 5-year limitation specified in this subsection may be extended if the holder of the exemption continues to take~~

~~affirmative steps to develop the property for the purposes specified in this subsection.~~

Section 3. Section 196.198, Florida Statutes, is amended to read:

196.198 Educational property exemption.—

<u>(1)</u> Educational institutions within this state and their property used by them or by any other exempt entity or educational institution exclusively for educational purposes are exempt from taxation.

<u>(a)</u> Sheltered workshops providing rehabilitation and retraining of individuals who have disabilities and exempted by a certificate under s. (d) of the federal Fair Labor Standards Act of 1938, as amended, are declared wholly educational in purpose and are exempt from certification, accreditation, and membership requirements set forth in s. 196.012.

<u>(b)</u> Those portions of property of college fraternities and sororities certified by the president of the college or university to the appropriate property appraiser as being essential to the educational process are exempt from ad valorem taxation.

<u>(c)</u> The use of property by public fairs and expositions chartered by chapter 616 is presumed to be an educational use of such property and is exempt from ad valorem taxation to the extent of such use.

<u>(2)</u> Property used exclusively for educational purposes shall be deemed owned by an educational institution if the

entity owning 100 percent of the educational institution is owned by the identical persons who own the property, or if the entity owning 100 percent of the educational institution and the entity owning the property are owned by the identical natural persons.

(a) Land, buildings, and other improvements to real property used exclusively for educational purposes shall be deemed owned by an educational institution if the entity owning 100 percent of the land is a nonprofit entity and the land is used, under a ground lease or other contractual arrangement, by an educational institution that owns the buildings and other improvements to the real property, is a nonprofit entity under s. 501(c)(3) of the Internal Revenue Code, and provides education limited to students in prekindergarten through grade 8.

(b) If legal title to property is held by a governmental agency that leases the property to a lessee, the property shall be deemed to be owned by the governmental agency and used exclusively for educational purposes if the governmental agency continues to use such property exclusively for educational purposes pursuant to a sublease or other contractual agreement with that lessee.

(c) If the title to land is held by the trustee of an irrevocable inter vivos trust and if the trust grantor owns 100 percent of the entity that owns an educational institution that is using the land exclusively for educational purposes, the land is deemed to be property owned by the educational institution for purposes of this exemption. ~~Property owned by an educational institution shall be deemed to be used for an educational purpose if the institution has taken affirmative steps to prepare the property for educational use. The term "affirmative steps" means environmental or land-use permitting activities, creation of architectural plans or schematic drawings, land clearing or site preparation, construction or renovation activities, or other similar activities that demonstrate commitment of the property to an educational use.~~

Section 4. This act shall take effect July 1, 2016.

CS/HB 445

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 hypothecating 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.

A bill to be entitled

An act relating to viatical settlements; amending s. 626.9911, F.S.; revising definitions; defining the terms "business of viatical settlements," "fraudulent viatical settlement act," and "stranger-originated life insurance practice"; amending s. 626.9913, F.S.; requiring additional information in an annual statement filed by viatical settlement provider licensees; revising deposit requirements for viatical settlement provider licensees; deleting an obsolete provision regarding a deposit requirement; authorizing the Financial Services Commission to adopt rules; amending s. 626.9914, F.S.; adding an act that warrants the imposition of administrative penalties against viatical settlement provider licensees; increasing the amount of administrative fines that may be imposed by the Office of Insurance Regulation against licensees for certain violations; amending s. 626.99175, F.S.; deleting an obsolete provision; deleting an exception from registration requirements for life expectancy providers; creating s. 626.99185, F.S.; requiring viatical settlement providers to provide viators with a disclosure statement before or concurrently with a viator's execution of a viatical settlement contract; providing requirements and procedures for such disclosure statements; amending s.

626.9924, F.S.; correcting cross-references relating to a requirement to provide specified documents with a notice that a policy has or will become a viaticated policy; amending s. 626.99245, F.S.; conforming a cross-reference; creating s. 626.99273, F.S.; prohibiting certain practices and conflicts of interest relating to viatical settlement contracts or insurance policies; requiring a viatical settlement provider to file certain promotional, advertising, and marketing materials with the office before entering into viatical settlement contracts; prohibiting certain references relating to the cost of life insurance policies in such materials and other specified statements and representations; authorizing the commission to adopt rules; amending s. 626.99275, F.S.; prohibiting a person from entering into a viatical settlement contract before a specified date except under specified circumstances, from issuing, soliciting, marketing, or otherwise promoting the purchase of a policy under certain circumstances, and from engaging in a fraudulent viatical settlement act; providing criminal penalties for a violation of such prohibitions; creating s. 626.99276, F.S.; requiring specified affidavits and other documentation to be provided to an insurer for requests to verify coverage and to transfer a policy or certificate to a viatical settlement provider; prohibiting insurers from requiring certain forms that have not been approved by the office to be signed as a condition of responding to such requests; requiring insurers to respond in writing during a specified period to properly completed requests to change the ownership or beneficiary of a policy; amending s. 626.99278, F.S.; providing requirements for licensed viatical settlement providers to maintain specified documentation relating to anti-fraud plans and procedures, material inconsistencies between medical records and insurance applications, and reporting of specified fraudulent acts and prohibited practices; amending s. 626.99287, F.S.; revising the period during which certain viatical settlement contracts are void and unenforeceable; revising exceptions to such contracts being void and unenforceable; creating s. 626.99289, F.S.; providing that certain contracts, agreements, arrangements, and transactions relating to stranger-originated life insurance practices are void and unenforceable; providing an effective date.

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

Section 1. Section 626.9911, Florida Statutes, is amended to read:

626.9911 Definitions.—As used in this act, the term:

(1) "Business of viatical settlements" means an activity involved in the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating of, or acquiring in other manner, an interest in a life insurance policy by means of a viatical settlement contract.

(2) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, or purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but whose principal activity related to the transaction is providing funds or credit enhancement to effect the viatical settlement or the purchase of one or more viaticated policies and who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. The term does not include a nonaccredited investor or other natural person. A financing entity may not enter into a viatical settlement contract.

(3) "Fraudulent viatical settlement act" means an act or omission committed by a person who, knowingly or with the intent to defraud for the purpose of depriving another of property or for pecuniary gain, commits or allows an employee or agent to

commit an act specified in this subsection.

(a) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person false or concealed material information as part of, in support of, or concerning a fact material to:

1. An application for the issuance of a viatical settlement contract or an insurance policy;

2. The underwriting of a viatical settlement contract or an insurance policy;

3. A claim for payment or benefit pursuant to a viatical settlement contract or an insurance policy;

4. Premiums paid on an insurance policy;

5. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or an insurance policy;

6. The reinstatement or conversion of an insurance policy;

7. The solicitation, offer, effectuation, or sale of a viatical settlement contract or an insurance policy;

8. The issuance of written evidence of a viatical settlement contract or an insurance policy; or

9. A financing transaction.

(b) Employing a plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.

(c) Engaging in a stranger-originated life insurance practice.

(d) Failing to disclose upon request by an insurer that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the policy.

(e) Perpetuating a fraud or preventing the detection of a fraud by:

1. Removing, concealing, altering, destroying, or sequestering from the office the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

3. Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or

4. Filing with the office or the equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from the office or other regulatory official.

(f) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business of viatical settlements or insurance.

(g) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy's issuer, viatical settlement provider, or viator. As used in this paragraph, the term "recklessly" means acting or failing to act in conscious disregard for the relevant facts or risks, and which disregard involves a gross deviation from acceptable standards of conduct.

(h) Facilitating the viator's change of residency state to avoid the provisions of this act.

(i) Facilitating or causing the creation of a trust with a non-Florida situs or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of this act.

(j) Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a non-Florida situs or other nonresident entity to avoid the provisions of this act.

(k) Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy.

(l) Violating s. 626.99273(1) or (2).

(m) Attempting to commit, assisting, aiding, or abetting in the commission of or conspiring to commit an act or omission specified in this subsection.

(4) ~~(2)~~ "Independent third-party trustee or escrow agent" means an attorney, certified public accountant, financial institution, or other person providing escrow services under the authority of a regulatory body. The term does not include any

person associated, affiliated, or under common control with a viatical settlement provider or viatical settlement broker.

(5)~~(3)~~ "Life expectancy" means an opinion or evaluation as to how long a particular person is to live, or relating to such person's expected demise.

(6)~~(4)~~ "Life expectancy provider" means a person who determines, or holds himself or herself out as determining, life expectancies or mortality ratings used to determine life expectancies under any of the following circumstances:

(a) On behalf of a viatical settlement provider, viatical settlement broker, life agent, or person engaged in the business of viatical settlements.~~;~~

(b) In connection with a viatical settlement investment, pursuant to s. 517.021(24).~~; or~~

(c) On residents of this state in connection with a viatical settlement contract or viatical settlement investment.

(7)~~(5)~~ "Person" has the meaning specified in s. 1.01.

(8)~~(6)~~ "Related form" means any form, created by or on behalf of a licensee, which a viator or insured is required to sign or initial. The forms include, but are not limited to, a power of attorney, a release of medical information form, a suitability questionnaire, a disclosure document, or any addendum, schedule, or amendment to a viatical settlement contract considered necessary by a provider to effectuate a viatical settlement transaction.

(9)~~(7)~~ "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with a licensed viatical settlement provider or financing entity under which the licensed viatical settlement provider or financing entity is responsible for insuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to viatical settlement transactions available to the office as if those records and files were maintained directly by the licensed viatical settlement provider. This term does not include an independent third-party trustee or escrow agent or a trust that does not enter into agreements with a viator. A related provider trust is ~~shall be~~ subject to all provisions of this act that apply to the viatical settlement provider who established the related provider trust, except s. 626.9912, which does ~~shall~~ not apply ~~be applicable~~. A viatical settlement provider may establish up to ~~no more than~~ one related provider trust, and the sole trustee of such related provider trust shall be the viatical settlement provider licensed under s. 626.9912. The name of the licensed viatical settlement provider shall be included within the name of the related provider trust.

(10)~~(8)~~ "Special purpose entity" means an entity established by a licensed viatical settlement provider or by a financing entity, which may be a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets to a viatical settlement provider or financing entity. A special purpose entity may not obtain capital from any natural person or entity with less than $50 million in assets and may not enter into a viatical settlement contract.

(11) "Stranger-originated life insurance practice" means 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. Stranger-originated life insurance practices include, but are not limited to:

(a) The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy's inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party.

(b) The creation of a trust or other entity that has the appearance of an insurable interest to initiate policies for investors, which violates insurable interest laws and the prohibition against wagering on life.

(12) ~~(9)~~ "Viatical settlement broker" means a person who, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical

settlement contracts between a viator resident in this state and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, licensed Certified Public Accountant, or investment adviser lawfully registered under chapter 517, who is retained to represent the viator and whose compensation is paid directly by or at the direction and on behalf of the viator.

(13) ~~(10)~~ "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider, or its related provider trust, and a viator. The viatical settlement contract includes an agreement to transfer ownership or change the beneficiary designation of a life insurance policy at a later date, regardless of the date that compensation is paid to the viator. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance to the viatical settlement provider. The term also includes the transfer for compensation or value of an ownership or a

beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or used for the principal purpose of acquiring one or more life insurance contracts that insure the life of a person residing in this state, and ~~A viatical settlement contract also includes~~ a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy. The term does not include~~, other than~~ a policy loan by a life insurance company pursuant to the terms of the life insurance contract or accelerated death provisions contained in a life insurance policy, whether issued with the original policy or as a rider, ~~or~~ a loan secured by the cash surrender value of a policy as determined by the policy issuer and the life insurance policy terms, or a loan or advance from the issuer of the policy to the policyowner.

(14)~~(11)~~ "Viatical settlement investment" has the same meaning as specified in s. 517.021.

(15)~~(12)~~ "Viatical settlement provider" means a person who, in this state, from this state, or with a resident of this state, effectuates a viatical settlement contract. The term does not include:

(a) A ~~Any~~ bank, savings bank, savings and loan association, or credit union~~, or other licensed lending institution~~ that takes an assignment of a life insurance policy as collateral for a loan.

(b) A life and health insurer that has lawfully issued a life insurance policy that provides accelerated benefits to terminally ill policyholders or certificateholders.

(c) A ~~Any~~ natural person who enters into no more than one viatical settlement contract with a viator in 1 calendar year, unless such natural person has previously been licensed under this act or is currently licensed under this act.

(d) A trust that meets the definition of a "related provider trust."

(e) A viator in this state.

(f) A financing entity.

(16)~~(13)~~ "Viaticated policy" means a life insurance policy, or a certificate under a group policy, which is the subject of a viatical settlement contract.

(17)~~(14)~~ "Viator" means the owner of a life insurance policy or a certificateholder under a group policy, which policy is not a previously viaticated policy, who enters or seeks to enter into a viatical settlement contract. This term does not include a viatical settlement provider, ~~or~~ a ~~any~~ person acquiring a policy or interest in a policy from a viatical settlement provider, or ~~nor does it include~~ an independent third-party trustee or escrow agent.

Section 2. Subsections (2) and (3) of section 626.9913, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

626.9913 Viatical settlement provider license continuance; annual report; fees; deposit.—

(2)<u>(a)</u> Annually, on or before March 1, the viatical settlement provider licensee shall file a statement containing information the commission requires and shall pay to the office a license fee in the amount of $500.

<u>(b) In addition to any other requirements, the annual statement must specify:</u>

<u>1. The total number of unsettled viatical settlement contracts and corresponding total amount due to viators under viatical settlement contracts that have been signed by the viator but have not been settled as of December 31 of the preceding calendar year, categorized by the number of days since the viator signed the contract for transactions regulated by this state.</u>

<u>2. For each of the most recent 5 years, the total number of policies purchased, total gross amount paid for policies purchased, total commissions or compensation paid for policies purchased, and total face value of policies purchased, allocated by state, territory, and jurisdiction.</u>

<u>3. For the most recent calendar year, the total amount of proceeds or compensation paid to policyowners, allocated by state, territory, and jurisdiction.</u>

<u>(c)</u> ~~After December 31, 2007,~~ The annual statement shall include an annual audited financial statement of the viatical settlement provider prepared in accordance with generally accepted accounting principles by an independent certified public accountant covering a 12-month period ending on a day

occurring within ~~falling during~~ the last 6 months of the preceding calendar year. If the audited financial statement has not been completed, however, the licensee shall include in its annual statement an unaudited financial statement for the preceding calendar year and an affidavit from an officer of the licensee stating that the audit has not been completed. In this event, the licensee shall submit the audited statement on or before June 1. The annual statement, due on or before March 1 each year, shall also provide the office with a report of all life expectancy providers who have provided life expectancies directly or indirectly to the viatical settlement provider for use in connection with a viatical settlement contract or a viatical settlement investment. A viatical settlement provider shall include in all statements filed with the office all information requested by the office regarding a related provider trust established by the viatical settlement provider. The office may require more frequent reporting. Failure to timely file the annual statement or the audited financial statement or to timely pay the license fee is grounds for immediate suspension of the license. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

(3) To ensure the faithful performance of its obligations to its viators in the event of insolvency or the loss of its

license, a viatical settlement provider licensee must deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52, having at all times a value of not less than $250,000 ~~$100,000; however, a viatical settlement provider licensed in this state prior to June 1, 2004, which has deposited and maintains continuously deposited in trust with the department securities in the amount of $25,000 and which posted and maintains continuously posted a security bond acceptable to the department in the amount of $75,000, has until June 1, 2005, to comply with the requirements of this subsection~~.

(6) The commission may adopt rules to implement this section.

Section 3. Subsections (1) and (2) of section 626.9914, Florida Statutes, are amended to read:

626.9914 Suspension, revocation, denial, or nonrenewal of viatical settlement provider license; grounds; administrative fine.—

(1) The office shall suspend, revoke, deny, or refuse to renew the license of any viatical settlement provider if the office finds that the licensee has committed any of the following acts:

(a) Has made a misrepresentation in the application for the license.~~;~~

(b) Has engaged in fraudulent or dishonest practices, or otherwise has been shown to be untrustworthy or incompetent to act as a viatical settlement provider.~~;~~

(c) Demonstrates a pattern of unreasonable payments to viators.~~;~~

(d) Has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court.~~;~~

(e) Has issued viatical settlement contracts that have not been approved pursuant to this act.~~;~~

(f) Has failed to honor contractual obligations related to the business of viatical settlement contracts.~~;~~

(g) Deals in bad faith with viators.~~;~~

(h) Has violated any provision of the insurance code or of this act.~~;~~

(i) Employs or contracts with a ~~any~~ person who materially influences the licensee's conduct and who fails to meet the requirements of this act.~~;~~

(j) No longer meets the requirements for initial licensure.~~; or~~

(k) Obtains or utilizes life expectancies from life expectancy providers who are not registered with the office pursuant to this act.

(l) Has engaged in a fraudulent viatical settlement act.

(2) The office may, in lieu of or in addition to any suspension or revocation, assess an administrative fine not to exceed $10,000 ~~$2,500~~ for each nonwillful violation or $25,000

~~$10,000~~ for each willful violation by a viatical settlement provider licensee. The office may also place a viatical settlement provider licensee on probation for a period not to exceed 2 years.

Section 4. Subsection (1) of section 626.99175, Florida Statutes, is amended to read:

626.99175 Life expectancy providers; registration required; denial, suspension, revocation.—

(1) ~~After July 1, 2006,~~ A person may not perform the functions of a life expectancy provider without first having registered as a life expectancy provider~~, except as provided in subsection (6)~~.

Section 5. Section 626.99185, Florida Statutes, is created to read:

626.99185 Disclosures to viator of disbursement.—

(1) Before or concurrently with a viator's execution of a viatical settlement contract, the viatical settlement provider shall provide to the viator, in duplicate, a disclosure statement in legible written form disclosing:

(a) The name of each viatical settlement broker who receives or will receive compensation and the amount of each broker's compensation related to that transaction. For the purpose of this section, compensation includes anything of value paid or given by or at the direction of a viatical settlement provider or person acquiring an interest in one or more life insurance policies to a viatical settlement broker in connection with the viatical settlement contract.

(b) A complete reconciliation of the gross offer or bid by the viatical settlement provider to the net amount of proceeds or value to be received by the viator related to that transaction. As used in this section, the term "gross offer" or "bid" means the total amount or value offered by the viatical settlement provider for the purchase of an interest in one or more life insurance policies, including commissions, compensation, or other proceeds or value being deducted from the gross offer or bid.

(2) The viator shall sign and date the disclosure statement before or concurrently with the viator's execution of a viatical settlement contract, with the viator retaining the duplicate copy of the disclosure statement.

(3) If a viatical settlement contract is entered into and the contract is subsequently amended or if there is a change in the viatical settlement provider's gross offer or bid amount, a change in the net amount of proceeds or value to be received by the viator, or a change in the information provided in the disclosure statement to the viator, the viatical settlement provider shall provide, in duplicate, an amended disclosure statement to the viator containing the information in subsection (1). The viator shall sign and date the amended disclosure statement, with the viator retaining the duplicate copy of the amended disclosure statement.

(4) Before a viatical settlement provider's execution of a

<u>viatical settlement contract or an amendment to such contract, the viatical settlement provider must obtain the signed and dated disclosure statement and any amended disclosure statement required by this section. In transactions for which a broker is not used, the viatical settlement provider must obtain the signed and dated disclosure statement from the viator.</u>

<u>(5) The viatical settlement provider shall maintain the documentation required by this section pursuant to s. 626.9922(2) and shall make such documentation available to the office at any time for copying and inspection upon reasonable notice by the office to the viatical settlement provider.</u>

Section 6. Subsection (7) of section 626.9924, Florida Statutes, is amended to read:

626.9924 Viatical settlement contracts; procedures; rescission.—

(7) At any time during the contestable period, within 20 days after a viator executes documents necessary to transfer rights under an insurance policy or within 20 days of any agreement, option, promise, or any other form of understanding, express or implied, to viaticate the policy, the provider must give notice to the insurer of the policy that the policy has or will become a viaticated policy. The notice must be accompanied by the documents required by <u>ss. 626.99276 and 626.99287</u> ~~s. 626.99287(5)(a)~~ in their entirety.

Section 7. Subsection (2) of section 626.99245, Florida Statutes, is amended to read:

626.99245 Conflict of regulation of viaticals.—

(2) This section does not affect the requirement of ss. 626.9911(15) ~~(12)~~ and 626.9912(1) that a viatical settlement provider doing business from this state must obtain a viatical settlement license from the office. As used in this subsection, the term "doing business from this state" includes effectuating viatical settlement contracts from offices in this state, regardless of the state of residence of the viator.

Section 8. Section 626.99273, Florida Statutes, is created to read:

626.99273 Prohibited practices and conflicts of interest.—

(1) With respect to a viatical settlement contract or an insurance policy, a viatical settlement broker may not knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

(2) With respect to a viatical settlement contract or an insurance policy, a viatical settlement provider may not knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider, financing entity, or related provider trust that is involved in such viatical settlement

contract.

(3) A viatical settlement provider may not enter into a viatical settlement contract unless the viatical settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the office. Such materials may not expressly indicate, or include any reference that would cause a viator to reasonably believe, that the life insurance is free for any period of time.

(4) A life insurance agent, insurer, viatical settlement broker, or viatical settlement provider may not make a statement or representation to an applicant or policyholder in connection with the sale of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time.

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

Section 9. Section 626.99275, Florida Statutes, is amended to read:

626.99275 Prohibited practices; penalties.—

(1) It is unlawful for a ~~any~~ person to:

(a) ~~To~~ Knowingly enter into, broker, or otherwise deal in a viatical settlement contract the subject of which is a life insurance policy, knowing that the policy was obtained by presenting materially false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer.

(b) ~~To~~ Knowingly or with the intent to defraud, for the purpose of depriving another of property or for pecuniary gain, issue or use a pattern of false, misleading, or deceptive life expectancies.

(c) ~~To~~ Knowingly engage in any transaction, practice, or course of business intending thereby to avoid the notice requirements of s. 626.9924(7).

(d) ~~To~~ Knowingly or intentionally facilitate the change of state of residency of a viator to avoid the provisions of this chapter.

(e) Knowingly enter into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of a viatical settlement contract or during the 5-year period commencing on the date of issuance of the policy or certificate, unless the viator provides a sworn affidavit and accompanying documentation in accordance with s. 626.9987.

(f) Knowingly issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy.

(g) Engage in a fraudulent viatical settlement act.

(2) A person who violates any provision of this section commits:

(a) A felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at any amount less than $20,000.

(b) A felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $20,000 or more, but less than $100,000.

(c) A felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $100,000 or more.

Section 10. Section 626.99276, Florida Statutes, is created to read:

626.99276 Notification to insurer required.—

(1) A copy of the sworn affidavit and the documentation required in s. 626.99287 must be submitted to the insurer if the viatical settlement provider or other party entering into a viatical settlement contract with a 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. If the request is made by a viatical settlement provider, the copy shall be accompanied by a sworn affidavit from the viatical settlement provider affirming that the copy is a true and correct copy of the documentation received by the provider.

(2) An insurer may not require, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical

settlement contract, that the viator, insured, viatical settlement provider, or viatical settlement broker sign any disclosures, consent form, waiver form, or other form that has not been approved by the office for use in connection with viatical settlement contracts in this state.

(3) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within 30 calendar days confirming that the change has been effectuated or specifying the reasons why the requested change cannot be processed. The insurer may not unreasonably delay effectuating a change of ownership or beneficiary and may not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Section 11. Section 626.99278, Florida Statutes, is amended to read:

626.99278 Viatical provider anti-fraud plan.—

(1) Each ~~Every~~ licensed viatical settlement provider and registered life expectancy provider must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department. Each anti-fraud plan shall include:

(a) ~~(1)~~ A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications.

(b) ~~(2)~~ A description of the procedures for the mandatory reporting of possible fraudulent insurance acts and prohibited practices specified ~~set forth~~ in s. 626.99275 to the Division of Insurance Fraud ~~of the department~~.

(c)~~(3)~~ A description of the plan for anti-fraud education and training of its underwriters or other personnel.

(d)~~(4)~~ A written description or chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and for the investigation of unresolved material inconsistencies between medical records and insurance applications.

(e)~~(5)~~ For viatical settlement providers, a description of the procedures used to perform initial and continuing review of the accuracy of life expectancies used in connection with a viatical settlement contract or viatical settlement investment.

(2) Each licensed viatical settlement provider shall maintain in accordance with s. 626.9922:

(a) Documentation of compliance with its anti-fraud plan and procedures filed in accordance with this section.

(b) Documentation pertaining to resolved and unresolved material inconsistencies between medical records and insurance applications.

(c) Documentation of its mandatory reporting of the possible fraudulent acts and prohibited practices specified in s. 626.99275 to the Division of Insurance Fraud.

Section 12. Section 626.99287, Florida Statutes, is amended, to read:

626.99287 Contestability of viaticated policies.—Except as hereinafter provided, if a viatical settlement contract is entered into during ~~within~~ the 5-year ~~2-year~~ period commencing on ~~with~~ the date of issuance of the insurance policy or certificate to be acquired, the viatical settlement contract is void and unenforceable by either party. Notwithstanding this limitation, such a viatical settlement contract is not void and unenforceable if the viator provides a sworn affidavit and accompanying documentation that certifies to the viatical settlement provider that one or more of the following conditions were met during the 5-year period:

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or term policy, if the total time covered under the prior policy is at least 60 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The owner of the policy is a charitable organization exempt from taxation under 26 U.S.C. s. 501(c)(3);

(3) The owner of the policy is not a natural person;

(4) The viatical settlement contract was entered into before July 1, 2000;

(5) The viator certifies by producing independent evidence to the viatical settlement provider that one or more of the

following conditions were ~~have been~~ met during ~~within~~ the 5-year ~~2-year~~ period:

(a)~~1.~~ The viator or insured is terminally or chronically ill ~~diagnosed with an illness or condition that is either:~~

~~a. Catastrophic or life threatening; or~~

~~b. Requires a course of treatment for a period of at least 3 years of long-term care or home health care;~~ and

~~2.~~ the condition was not known to the insured at the time the life insurance contract was entered into;~~.~~

(b) The viator's spouse dies;

(c) The viator divorces his or her spouse;

(d) The viator retires from full-time employment;

(e) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

(f) The owner of the policy was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;

(g) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets; or

(h) The viator experiences a significant decrease in income which is unexpected by the viator and which impairs his or her reasonable ability to pay the policy premium.

(6) The viator entered into a viatical settlement contract more than 2 years after the policy's issuance date and, with respect to the policy, at all times before such date each of the following conditions were met:

(a) Policy premiums were funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed but only to the extent of its net cash surrender value provided by or full recourse liability incurred by the insured;

(b) An agreement or understanding with another person was not entered into to guarantee any such liability or to purchase, or agree to purchase, the policy, including through an assumption or forgiveness of the loan; and

(c) The insured and the policy were not evaluated for settlement.

~~If the viatical settlement provider submits to the insurer a copy of the viator's or owner's certification described above, then the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the viatical settlement agreement shall not be void or unenforceable by operation of this section. The insurer shall timely respond to such request. Nothing in this section shall prohibit an insurer from exercising its right during the contestability period to contest the validity of any policy on~~

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

~~grounds of fraud.~~

Section 13. Section 626.99289, Florida Statutes, is created to read:

626.99289 Void and unenforceable contracts, agreements, arrangements, and transactions.—A contract, agreement, arrangement, or transaction, including, but not limited to, a financing agreement or any other arrangement or understanding entered into, whether written or verbal, for the furtherance or aid of a stranger-originated life insurance practice is void and unenforceable.

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 TP	Leznoff JV

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 <u>within the right-of-way limits of</u>," but not "<u>along</u>," 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 <u>within the right-of-way limits of</u>," but not "<u>along</u>," 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. **<u>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.</u>**

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

[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.).

[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.

A bill to be entitled

An act relating to the location of utilities; amending s. 125.42, F.S.; revising the circumstances under which a board of county commissioners is authorized to grant to a person or private corporation a license for specified projects related to lines for the transmission of certain public utilities and communication services; conforming a cross-reference; amending s. 337.401, F.S.; authorizing the Department of Transportation and certain local governmental entities to prescribe and enforce rules or regulations regarding the placement and maintenance of specified structures and lines within the right-of-way limits of roads or publicly owned rail corridors under their respective jurisdictions; conforming cross-references; amending s. 337.403, F.S.; specifying that the owner of a utility located within certain right-of-way limits must initiate and bear the cost necessary to alleviate any interference to the use of certain public roads or rail corridors under certain circumstances; conforming a cross-reference; requiring the authority to bear the cost of the utility work necessary to eliminate an unreasonable interference if the utility is lawfully located within a certain utility easement, subject to certain deductions; providing findings of an important state interest;

providing an effective date.

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

Section 1. Section 125.42, Florida Statutes, is amended to read:

125.42 Water, sewage, gas, power, telephone, other utility, and television lines within the right-of-way limits of ~~along~~ county roads and highways.—

(1) The board of county commissioners, with respect to property located without the corporate limits of any municipality, is authorized to grant a license to any person or private corporation to construct, maintain, repair, operate, and remove lines for the transmission of water, sewage, gas, power, telephone, other public utilities, ~~and~~ television, or other communications services as defined in s. 202.11(1) under, on, over, across, or within the right-of-way limits of ~~and along~~ any county highway or any public road or highway acquired by the county or public by purchase, gift, devise, dedication, or prescription. However, the board of county commissioners shall include in any instrument granting such license adequate provisions:

(a) To prevent the creation of any obstructions or conditions which are or may become dangerous to the traveling public;

(b) To require the licensee to repair any damage or injury to the road or highway by reason of the exercise of the privileges granted in any instrument creating such license and to repair the road or highway promptly, restoring it to a condition at least equal to that which existed immediately prior to the infliction of such damage or injury;

(c) Whereby the licensee shall hold the board of county commissioners and members thereof harmless from the payment of any compensation or damages resulting from the exercise of the privileges granted in any instrument creating the license; and

(d) As may be reasonably necessary, for the protection of the county and the public.

(2) A license may be granted in perpetuity or for a term of years, subject, however, to termination by the licensor, in the event the road or highway is closed, abandoned, vacated, discontinued, or reconstructed.

(3) The board of county commissioners is authorized to grant exclusive or nonexclusive licenses for the purposes stated herein for television.

(4) This law is intended to provide an additional method for the granting of licenses and shall not be construed to repeal any law now in effect relating to the same subject.

(5) In the event of widening, repair, or reconstruction of any such road, the licensee shall move or remove such water, sewage, gas, power, telephone, and other utility lines and television lines at no cost to the county should they be found by the county to be unreasonably interfering, except as provided

in s. 337.403(1)(d)-(j) ~~s. 337.403(1)(d)-(i)~~.

Section 2. Paragraph (a) of subsection (1) of section 337.401, Florida Statutes, is amended to read:

337.401 Use of right-of-way for utilities subject to regulation; permit; fees.—

(1)(a) The department and local governmental entities, referred to in this section and in ss. 337.402, 337.403, and 337.404 ~~ss. 337.401-337.404~~ as the "authority," that have jurisdiction and control of public roads or publicly owned rail corridors are authorized to prescribe and enforce reasonable rules or regulations with reference to the placing and maintaining ~~along,~~ across, ~~or~~ on, or within the right-of-way limits of any road or publicly owned rail corridors under their respective jurisdictions 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; or other structures referred to in this section and in ss. 337.402, 337.403, and 337.404 as the "utility." The department may enter into a permit-delegation agreement with a governmental entity if issuance of a permit is based on requirements that the department finds will ensure the safety and integrity of facilities of the Department of Transportation; however, the permit-delegation agreement does not apply to facilities of electric utilities as defined in s. 366.02(2).

Section 3. Subsection (1) of section 337.403, Florida

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

Statutes, is amended to read:

337.403 Interference caused by utility; expenses.—

(1) If a utility that is placed upon, under, over, or within the right-of-way limits of ~~along~~ any public road or publicly owned rail corridor is found by the authority to be unreasonably interfering in any way with the convenient, safe, or continuous use, or the maintenance, improvement, extension, or expansion, of such public road or publicly owned rail corridor, the utility owner shall, upon 30 days' written notice to the utility or its agent by the authority, initiate the work necessary to alleviate the interference at its own expense except as provided in paragraphs (a)-(j) ~~(a)-(i)~~. The work must be completed within such reasonable time as stated in the notice or such time as agreed to by the authority and the utility owner.

(a) If the relocation of utility facilities, as referred to in s. 111 of the Federal-Aid Highway Act of 1956, Pub. L. No. 84-627, is necessitated by the construction of a project on the federal-aid interstate system, including extensions thereof within urban areas, and the cost of the project is eligible and approved for reimbursement by the Federal Government to the extent of 90 percent or more under the Federal Aid Highway Act, or any amendment thereof, then in that event the utility owning or operating such facilities shall perform any necessary work upon notice from the department, and the state shall pay the entire expense properly attributable to such work after deducting therefrom any increase in the value of a new facility and any salvage value derived from an old facility.

(b) When a joint agreement between the department and the utility is executed for utility work to be accomplished as part of a contract for construction of a transportation facility, the department may participate in those utility work costs that exceed the department's official estimate of the cost of the work by more than 10 percent. The amount of such participation is limited to the difference between the official estimate of all the work in the joint agreement plus 10 percent and the amount awarded for this work in the construction contract for such work. The department may not participate in any utility work costs that occur as a result of changes or additions during the course of the contract.

(c) When an agreement between the department and utility is executed for utility work to be accomplished in advance of a contract for construction of a transportation facility, the department may participate in the cost of clearing and grubbing necessary to perform such work.

(d) If the utility facility was initially installed to exclusively serve the authority or its tenants, or both, the authority shall bear the costs of the utility work. However, the authority is not responsible for the cost of utility work related to any subsequent additions to that facility for the purpose of serving others. For a county or municipality, if such utility facility was installed in the right-of-way as a means to serve a county or municipal facility on a parcel of property adjacent to the right-of-way and if the intended use of the county or municipal facility is for a use other than transportation purposes, the obligation of the county or municipality to bear the costs of the utility work shall extend only to utility work on the parcel of property on which the facility of the county or municipality originally served by the utility facility is located.

(e) If, under an agreement between a utility and the 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 the cost of necessary utility work, the authority shall bear the cost of removal or relocation. This paragraph does not impair or restrict, and may not be used to interpret, the terms of any such agreement entered into before July 1, 2009.

(f) If the utility is an electric facility being relocated underground in order to enhance vehicular, bicycle, and pedestrian safety and in which ownership of the electric facility to be placed underground has been transferred from a private to a public utility within the past 5 years, the department shall incur all costs of the necessary utility work.

(g) An authority may bear the costs of utility work required to eliminate an unreasonable interference when the utility is not able to establish that it has a compensable property right in the particular property where the utility is located if:

1. The utility was physically located on the particular property before the authority acquired rights in the property;

2. The utility demonstrates that it has a compensable property right in adjacent properties along the alignment of the utility or, after due diligence, certifies that the utility does not have evidence to prove or disprove that it has a compensable property right in the particular property where the utility is located; and

3. The information available to the authority does not establish the relative priorities of the authority's and the utility's interests in the particular property.

(h) If a municipally owned utility or county-owned utility is located in a rural area of opportunity, as defined in s. 288.0656(2), and the department 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 department project on the State Highway System, the department may pay, in whole or in part, the cost of such utility work performed by the department or its contractor.

(i) If the relocation of utility facilities is necessitated by the construction of a commuter rail service project or an intercity passenger rail service project and the cost of the project is eligible and approved for reimbursement by the Federal Government, then in that event the utility owning or operating such facilities located by permit on a department-owned rail corridor shall perform any necessary utility relocation work upon notice from the department, and the department shall pay the expense properly attributable to such utility relocation work in the same proportion as federal funds are expended on the commuter rail service project or an intercity passenger rail service project after deducting therefrom any increase in the value of a new facility and any salvage value derived from an old facility. In no event shall the state be required to use state dollars for such utility relocation work. This paragraph does not apply to any phase of the Central Florida Commuter Rail project, known as SunRail.

(j) If a utility is lawfully located within an existing and valid utility easement granted by recorded plat, regardless of whether such land was subsequently acquired by the authority by dedication, transfer of fee, or otherwise, the authority must bear the cost of the utility work required to eliminate an unreasonable interference. 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.

Section 4. 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.

Section 5. This act shall take effect upon becoming a law.

CS/HB 761

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

[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.

A bill to be entitled

An act relating to fraudulent activities associated with payment systems; amending s. 316.80, F.S.; revising the felony classification for unlawful conveyance of fuel; amending s. 525.07, F.S; revising terminology to specify requirements for managers, rather than operators, of petroleum fuel measuring devices with respect to accurate measurement; requiring retail petroleum fuel measuring devices fitted with scanning devices to have certain security measures; providing requirements for such measures; requiring the owner or operator of a device to have certain security measures in place within a specified timeframe upon notice from the Department of Agriculture and Consumer Services; authorizing the department, under certain circumstances, to prohibit use of or to remove from service such devices that are noncompliant; defining terms; providing applicability; requiring the Department of Agriculture and Consumer Services to enforce provisions; providing for rulemaking; amending s. 817.611, F.S.; reducing the number of counterfeit credit cards that a person can be in possession of to qualify as unlawful; amending s. 921.0022, F.S.; ranking unlawful conveyance or fraudulent acquisition of fuel as a level 5 offense; ranking trafficking in or possession of counterfeit credit cards as a level 5 offense; providing an effective date.

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

Section 1. Subsection (2) of section 316.80, Florida Statutes, is amended to read:

316.80 Unlawful conveyance of fuel; obtaining fuel fraudulently.—

(2) A ~~Any~~ person who violates subsection (1) commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if he or she has attempted to or has fraudulently obtained motor or diesel fuel by:

(a) Presenting a credit card or a credit card account number in violation of ss. 817.57-817.685;

(b) Using unauthorized access to any computer network in violation of s. 815.06; or

(c) Using a fraudulently scanned or lost or stolen payment access device, whether credit card or contactless device.

Section 2. Subsections (3) and (4) of section 525.07, Florida Statutes, are amended, and subsection (10) is added to that section, to read:

525.07 Powers and duties of department; inspections; unlawful acts.—

(3) Each person who owns or manages ~~All persons who own or operate~~ a petroleum fuel measuring device is ~~shall be~~

responsible for ensuring accurate measure by the device within the tolerances defined by the rule. An appropriate security seal shall be placed on all measuring devices found to be giving accurate measure within the tolerances defined by the department in such a way that the metering adjustment cannot be changed without breaking the seal.

(4) <u>A</u> ~~Any~~ measuring device that is found to be operating outside the tolerances defined by the department <u>is</u> ~~shall be~~ deemed inaccurate<u>,</u> and the department, at its discretion, shall either:

(a) Give, in writing, the ~~operator or~~ owner <u>or manager</u> of the measuring device a reasonable time to repair the measuring device; or

(b) 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. The measuring device shall not be operated in this state again without the written consent of the department.

<u>(10)(a) Each person who owns or manages a retail petroleum fuel measuring device shall have affixed to or installed onto the measuring device a security measure to restrict the unauthorized access of customer payment card information. The security measure must include one or more of the following:</u>

<u>1. Placement of pressure-sensitive security tape over the panel opening that leads to the scanning device for the retail petroleum fuel measuring device in a manner that will restrict</u>

the unauthorized opening of the panel.

2. A device or system that will render the retail petroleum fuel measuring device or the scanning device in the measuring device inoperable if there is an unauthorized opening of the panel.

3. A device or system that encrypts the customer payment card information in the scanning device.

4. Another security measure approved by the department.

(b) The owner or manager of a retail petroleum fuel measuring device without a security measure or with an altered or damaged security measure, upon written notice from the department of such noncompliance, shall have 5 calendar days to comply with this subsection. After the fifth day of noncompliance, the department may prohibit further use of the retail petroleum fuel measuring device until a security measure is installed, replaced, or repaired. A repeat violation found on the same retail petroleum fuel measuring device is cause for the department to immediately take the measuring device out of service.

(c) For purposes of this subsection, the terms "scanning device" and "payment card" have the same meanings as provided in s. 817.625.

(d) This subsection applies only to retail petroleum fuel measuring devices that have a scanning device.

(e) The department shall enforce, and may adopt rules to implement, this subsection.

Section 3. Section 817.611, Florida Statutes, is amended to read:

817.611 Traffic in <u>or possess</u> counterfeit credit cards.—Any person who traffics in<u>,</u> ~~or~~ attempts to traffic in<u>, or possesses 5</u> ~~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 6-month period is guilty of a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 4. Paragraph (e) of subsection (3) of section 921.0022, Florida Statutes, is amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

(e) LEVEL 5

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

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.
381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
624.401(4)(b)2.	2nd	Transacting insurance

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

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

		or more and one or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
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.

827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
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.
843.01	3rd	Resist officer with violence to person; resist arrest with violence.
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.
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.
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.
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.
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).
893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or

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

manufacturing of controlled substance.

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.

[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.

A bill to be entitled

An act relating to mental health treatment; amending s. 916.107, F.S.; provides for continuation of psychotropic medication by forensic and civil facilities for individuals receiving such medication before admission; amending s. 916.13, F.S.; providing a timeframe within which competency hearings must be held; requiring that a defendant be transported for the hearing; amending s. 916.145, F.S.; revising the time for dismissal of certain charges for defendants who remain incompetent to proceed to trial; providing exceptions; amending s. 916.15, F.S.; providing a timeframe within which commitment hearings must be held; requiring that a defendant be transported for the hearing; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 916.107, Florida Statutes, is amended to read:

916.107 Rights of forensic clients.—

(3) RIGHT TO EXPRESS AND INFORMED CONSENT.—

(a) A forensic client shall be asked to give express and informed written consent for treatment. If a client refuses such treatment as is deemed necessary and essential by the client's multidisciplinary treatment team for the appropriate care of the client, such treatment may be provided under the following circumstances:

1. In an emergency situation in which there is immediate danger to the safety of the client or others, such treatment may be provided upon the written order of a physician for <u>up to</u> ~~a period not to exceed~~ 48 hours, excluding weekends and legal holidays. If, after the 48-hour period, the client has not given express and informed consent to the treatment initially refused, the administrator or designee of the civil or forensic facility shall, within 48 hours, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of the client. In the interim, the need for treatment shall be reviewed every 48 hours and may be continued without the consent of the client upon the continued written order of a physician who has determined that the emergency situation continues to present a danger to the safety of the client or others.

2. In a situation other than an emergency situation, the administrator or designee of the facility shall petition the court for an order authorizing necessary and essential treatment for the client.

<u>a. If the client has been receiving psychotropic medication at the jail at the time of transfer to the forensic or civil facility and lacks the capacity to make an informed</u>

decision regarding mental health treatment at the time of admission, the admitting physician shall order continued administration of psychotropic medication if, in the clinical judgment of the physician, abrupt cessation of that psychotropic medication could pose a risk to the health or safety of the client while a court order to medicate is pursued. The administrator or designee of the forensic or civil facility shall, within 5 days after a client's admission, excluding weekends and legal holidays, petition the committing court or the circuit court serving the county in which the facility is located, at the option of the facility administrator or designee, for an order authorizing the continued treatment of a client with psychotropic medication. The jail physician shall provide a current psychotropic medication order at the time of transfer to the forensic or civil facility or upon request of the admitting physician after the client is evaluated.

b. The court order shall allow such treatment for up to ~~a period not to exceed~~ 90 days after ~~following~~ the date that ~~of the entry of~~ the order was entered. Unless the court is notified in writing that the client has provided express and informed written consent ~~in writing~~ or that the client has been discharged by the committing court, the administrator or designee of the facility shall, before the expiration of the initial 90-day order, petition the court for an order authorizing the continuation of treatment for an additional 90 days ~~another 90-day period~~. This procedure shall be repeated until the client provides consent or is discharged by the committing court.

3. At the hearing on the issue of whether the court should enter an order authorizing treatment for which a client was unable to or refused to give express and informed consent, the court shall determine by clear and convincing evidence that the client has mental illness, intellectual disability, or autism, that the treatment not consented to is essential to the care of the client, and that the treatment not consented to is not experimental and does not present an unreasonable risk of serious, hazardous, or irreversible side effects. In arriving at the substitute judgment decision, the court must consider at least the following factors:

a. The client's expressed preference regarding treatment;

b. The probability of adverse side effects;

c. The prognosis without treatment; and

d. The prognosis with treatment.

The hearing shall be as convenient to the client as may be consistent with orderly procedure and shall be conducted in physical settings not likely to be injurious to the client's condition. The court may appoint a general or special magistrate to preside at the hearing. The client or the client's guardian, and the representative, shall be provided with a copy of the petition and the date, time, and location of the hearing. The client has the right to have an attorney represent him or her at the hearing, and, if the client is indigent, the court shall appoint the office of the public defender to represent the client at the hearing. The client may testify or not, as he or she chooses, and has the right to cross-examine witnesses and may present his or her own witnesses.

Section 2. Subsection (2) of section 916.13, Florida Statutes, is amended to read:

916.13 Involuntary commitment of defendant adjudicated incompetent.—

(2) A defendant who has been charged with a felony and who has been adjudicated incompetent to proceed due to mental illness, and who meets the criteria for involuntary commitment ~~to the department~~ under ~~the provisions of~~ this chapter, may be committed to the department, and the department shall retain and treat the defendant.

<u>(a) Within</u> ~~No later than~~ 6 months after the date of admission and at the end of any period of extended commitment, or at any time the administrator or designee <u>determines</u> ~~shall have determined~~ that the defendant has regained competency to proceed or no longer meets the criteria for continued commitment, the administrator or designee shall file a report with the court pursuant to the applicable Florida Rules of Criminal Procedure.

<u>(b) A competency hearing shall be held within 30 days after the court receives notification that the defendant is competent to proceed or no longer meets the criteria for</u>

continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing.

Section 3. Section 916.145, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 916.145, F.S., for present text.)

916.145 Dismissal of charges.—

(1) The charges against a defendant adjudicated incompetent to proceed due to mental illness shall be dismissed without prejudice to the state if the defendant remains incompetent to proceed for 5 continuous, uninterrupted years after such determination, unless the court in its order specifies its reasons for believing that the defendant will become competent to proceed within the foreseeable future and specifies the time within which the defendant is expected to become competent to proceed. The court may dismiss such charges after at least 3 years but not more than 5 years after such determination, unless the charge is:

(a) Arson;

(b) Sexual battery;

(c) Robbery;

(d) Kidnapping;

(e) Aggravated child abuse;

(f) Aggravated abuse of an elderly person or disabled adult;

(g) Aggravated assault with a deadly weapon;

(h) Murder;

(i) Manslaughter;

(j) Aggravated manslaughter of an elderly person or disabled adult;

(k) Aggravated manslaughter of a child;

(l) Unlawful throwing, projecting, placing, or discharging of a destructive device or bomb;

(m) Armed burglary;

(n) Aggravated battery;

(o) Aggravated stalking;

(p) A forcible felony as defined in s. 776.08 and not listed elsewhere in this subsection;

(q) An offense where an element of the offense requires the possession, use, or discharge of a firearm;

(r) An attempt to commit an offense listed in this subsection;

(s) An offense allegedly committed by a defendant who has had a forcible or violent felony conviction within the 5 years immediately preceding the date of arrest for the nonviolent felony sought to be dismissed;

(t) An offense allegedly committed by a defendant who, after having been found incompetent and placed under court supervision in a community-based program, is formally charged by a state attorney or the Office of the Statewide Prosecutor with a new felony offense; or

(u) An offense for which there is an identifiable victim

<u>and such victim has not consented to the dismissal.</u>

<u>(2) This section does not prohibit the state from refiling dismissed charges if the defendant is declared to be competent to proceed in the future.</u>

Section 4. Subsection (5) is added to section 916.15, Florida Statutes, to read:

916.15 Involuntary commitment of defendant adjudicated not guilty by reason of insanity.—

<u>(5) The commitment hearing shall be held within 30 days after the court receives notification that the defendant no longer meets the criteria for continued commitment. The defendant must be transported to the committing court's jurisdiction for the hearing.</u>

Section 5. This act shall take effect July 1, 2016.

PCS for HB 873

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:

<u>Charter School Capital Outlay</u>

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:

[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

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[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]

[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 $1/40^{th}$ 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 $1/40^{th}$ calculated amount. The bill provides for the amount of the $1/40^{th}$ 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.

A bill to be entitled

An act relating to education funding; amending s. 1011.71, F.S.; providing for the calculation and payment of capital outlay funding to charter schools; providing that enterprise resource software may be acquired by certain means; amending 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; amending 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 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; 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; providing an effective date.

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

Section 1. Subsection (2) of section 1011.71, Florida Statutes, is amended to read:

1011.71 District school tax.—

(2) In addition to the maximum millage levy as provided in subsection (1), each school board may levy not more than 1.5 mills against the taxable value for school purposes for district schools, including charter schools<u>. A charter school shall be provided an amount equal to the remaining balance of funding needed to achieve the amount of the state funding allocation provided in s. 1013.62 after the amount of state appropriations is deducted. Annually, by December 30, the department shall calculate the amount of payments to eligible charter schools using the certified taxable value and millage rate as provided in the TRIM notice pursuant to s. 200.065 and certify to each school district the amount the school district must pay to each charter school based on the remaining balance of funding needed to achieve the amount of the state funding allocation as provided in s. 1013.62 after the amount of state appropriations is deducted. School districts shall make payments to charter schools no later than February 1 of each year, beginning on February 1, 2017, for the 2016-2017 fiscal year. Revenues retained by a school district after payments are made to charter schools may be used by the school district</u> ~~at the discretion of the school board,~~ to fund:

(a) New construction and remodeling projects, as set forth in s. 1013.64(3)(b) and (6)(b) and included in the district's educational plant survey pursuant to s. 1013.31, without regard to prioritization, sites and site improvement or expansion to new sites, existing sites, auxiliary facilities, athletic facilities, or ancillary facilities.

(b) Maintenance, renovation, and repair of existing school plants or of leased facilities to correct deficiencies pursuant to s. 1013.15(2).

(c) The purchase, lease-purchase, or lease of school buses.

(d) The purchase, lease-purchase, or lease of new and replacement equipment; computer hardware, including electronic hardware and other hardware devices necessary for gaining access to or enhancing the use of electronic content and resources or to facilitate the access to and the use of a school district's digital classrooms plan pursuant to s. 1011.62, excluding software other than the operating system necessary to operate the hardware or device; and enterprise resource software applications that are 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 districtwide administration or state-mandated reporting requirements. Enterprise resource software may be acquired by annual license fees, maintenance fees, or lease agreements.

(e) Payments for educational facilities and sites due under a lease-purchase agreement entered into by a district school board pursuant to s. 1003.02(1)(f) or s. 1013.15(2), not exceeding, in the aggregate, an amount equal to three-fourths of the proceeds from the millage levied by a district school board pursuant to this subsection. The three-fourths limit is waived for lease-purchase agreements entered into before June 30, 2009, by a district school board pursuant to this paragraph.

(f) Payment of loans approved pursuant to ss. 1011.14 and 1011.15.

(g) Payment of costs directly related to complying with state and federal environmental statutes, rules, and regulations governing school facilities.

(h) Payment of costs of leasing relocatable educational facilities, of renting or leasing educational facilities and sites pursuant to s. 1013.15(2), or of renting or leasing buildings or space within existing buildings pursuant to s. 1013.15(4).

(i) Payment of the cost of school buses when a school district contracts with a private entity to provide student transportation services if the district meets the requirements of this paragraph.

1. The district's contract must require that the private entity purchase, lease-purchase, or lease, and operate and maintain, one or more school buses of a specific type and size that meet the requirements of s. 1006.25.

2. Each such school bus must be used for the daily transportation of public school students in the manner required by the school district.

3. Annual payment for each such school bus may not exceed 10 percent of the purchase price of the state pool bid.

4. The proposed expenditure of the funds for this purpose must have been included in the district school board's notice of proposed tax for school capital outlay as provided in s. 200.065(10).

(j) Payment of the cost of the opening day collection for the library media center of a new school.

Section 2. Subsections (1) and (2) of section 1013.62, Florida Statutes, are amended to read:

1013.62 Charter schools capital outlay funding.—

(1) In each year in which funds are appropriated for charter school capital outlay purposes, the Commissioner of Education shall allocate the funds among eligible charter schools.

(a) To be eligible for a funding allocation, a charter school must:

1.a. Have been in operation for 2 ~~3~~ or more years;

b. Have no 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 under the National School Lunch Act ~~Be governed by a governing board established in the state for 3 or more years which operates both charter schools and conversion charter schools within the state~~;

c. Have an annual audit that does not reveal any of the financial emergency conditions provided in s. 218.503(1) for the most recent fiscal year for which such audit results are available ~~Be an expanded feeder chain of a charter school within the same school district that is currently receiving charter school capital outlay funds~~;

d. Have received final approval from its sponsor pursuant to s. 1002.33 for operation during that fiscal year; and

e. Serve students in facilities that are not provided by the charter school's sponsor; or

~~d. Have been accredited by the Commission on Schools of the Southern Association of Colleges and Schools; or~~

~~e. Serve students in facilities that are provided by a business partner for a charter school-in-the-workplace pursuant to s. 1002.33(15)(b).~~

2.a. Be part of a high-performing charter school system pursuant to s. 1002.332; ~~Have financial stability for future operation as a charter school.~~

~~3. Have satisfactory student achievement based on state accountability standards applicable to the charter school.~~

b.~~4.~~ Have received final approval from its sponsor pursuant to s. 1002.33 for operation during that fiscal year; and~~.~~

c.~~5.~~ Serve students in facilities that are not provided by the charter school's sponsor.

~~(b) The first priority for charter school capital outlay funding is to allocate to charter schools that received funding in the 2005-2006 fiscal year an allocation of the same amount~~

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~~per capital outlay full-time equivalent student, up to the lesser of the actual number of capital outlay full-time equivalent students in the current year, or the capital outlay full-time equivalent students in the 2005-2006 fiscal year. After calculating the first priority, the second priority is to allocate excess funds remaining in the appropriation in an amount equal to the per capital outlay full-time equivalent student amount in the first priority calculation to eligible charter schools not included in the first priority calculation and to schools in the first priority calculation with growth greater than the 2005-2006 capital outlay full-time equivalent students. After calculating the first and second priorities, excess funds remaining in the appropriation must be allocated to all eligible charter schools.~~

(b) ~~(c)~~ A charter school's allocation may not exceed one-fortieth ~~one-fifteenth~~ of the cost per student station specified in s. 1013.64(6)(b) or the amount of revenue per fixed capital outlay full-time equivalent student generated by the school district's levy of 1.5 mills pursuant to s. 1011.71(2), whichever is less. Before releasing capital outlay funds to a school district on behalf of the charter school, the Department of Education must ensure that the district school board and the charter school governing board enter into a written agreement that provides for the reversion of any unencumbered funds and all equipment and property purchased with public education funds to the ownership of the district school board, as provided for in subsection (3) if the school terminates operations. Any funds recovered by the state shall be deposited in the General Revenue Fund.

(c)~~(d)~~ A charter school is not eligible for a funding allocation if it was created by the conversion of a public school and operates in facilities provided by the charter school's sponsor for a nominal fee, or at no charge, or if it is directly or indirectly operated by the school district.

(d)~~(e)~~ Unless otherwise provided in the General Appropriations Act, the state funding allocation for each eligible charter school shall be ~~is~~ determined by multiplying the school's projected student enrollment by one-fortieth ~~one-fifteenth~~ of the cost-per-student station specified in s. 1013.64(6)(b) for an elementary, middle, or high school, as appropriate. If the funds appropriated are not sufficient, the charter school shall receive funding to achieve one-fortieth of the cost per student station or the amount of revenue per fixed capital outlay full-time equivalent student generated by the school district's levy of 1.5 mills pursuant to s. 1011.71(2), whichever is less, from the revenues generated by the school district levy of ad valorem property taxes ~~the commissioner shall prorate the available funds among eligible charter schools~~. ~~However,~~ A charter school or charter lab school may not receive state charter school capital outlay funds or local ad valorem capital outlay funds greater than the one-fortieth ~~one-fifteenth~~ cost per student station formula if the charter

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school's combination of state charter school capital outlay funds, capital outlay funds calculated through the reduction in the administrative fee provided in s. 1002.33(20), and capital outlay funds allowed in s. 1002.32(9)(e) and (h) exceeds the one-fortieth ~~one-fifteenth~~ cost per student station formula.

(e) ~~(f)~~ Funds shall be distributed on the basis of the capital outlay full-time equivalent membership by grade level, which is calculated by averaging the results of the second and third enrollment surveys. The Department of Education shall distribute capital outlay funds monthly, beginning in the first quarter of the fiscal year, based on one-twelfth of the amount the department reasonably expects the charter school to receive during that fiscal year. The commissioner shall adjust subsequent distributions as necessary to reflect each charter school's actual student enrollment as reflected in the second and third enrollment surveys. The commissioner shall establish the intervals and procedures for determining the projected and actual student enrollment of eligible charter schools.

(2) A charter school's governing body may use charter school capital outlay funds received pursuant to this section and s. 1011.71(2) for the following purposes:

(a) Purchase of real property.

(b) Construction of school facilities.

(c) Purchase, lease-purchase, or lease of permanent or relocatable school facilities.

(d) Purchase of vehicles to transport students to and from the charter school.

(e) Renovation, repair, and maintenance of school facilities that the charter school owns or is purchasing through a lease-purchase or long-term lease of 5 years or longer.

~~(f) Effective July 1, 2008, purchase, lease-purchase, or lease of new and replacement equipment, and enterprise resource software applications that are 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.~~

(f) ~~(g)~~ Payment of the cost of premiums for property and casualty insurance necessary to insure the school facilities.

(g) ~~(h)~~ 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.

(h) Purchase, lease-purchase, or lease of new and replacement equipment; computer hardware, including electronic hardware and other hardware devices necessary for gaining access to or enhancing the use of electronic content and resources or to facilitate the access to and the use of a charter school's digital classrooms plan pursuant to s. 1011.62, excluding software other than the operating system necessary to operate the hardware or device; and enterprise resource software

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applications that are 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. Enterprise resource software may be acquired by annual license fees, maintenance fees, or lease agreement.

(i) Payment of the cost of the opening day collection for the library media center of a new school.

Conversion charter schools may use capital outlay funds received through the reduction in the administrative fee provided in s. 1002.33(20) for renovation, repair, and maintenance of school facilities that are owned by the sponsor.

Section 3. Paragraphs (a) and (b) of subsection (2) and paragraphs (b), (c), (d), and (e) of subsection (6) of section 1013.64, Florida Statutes, are amended to read:

1013.64 Funds for comprehensive educational plant needs; construction cost maximums for school district capital projects.—Allocations from the Public Education Capital Outlay and Debt Service Trust Fund to the various boards for capital outlay projects shall be determined as follows:

(2)(a) The department shall establish, as a part of the Public Education Capital Outlay and Debt Service Trust Fund, a separate account, in an amount determined by the Legislature, to be known as the "Special Facility Construction Account." The Special Facility Construction Account shall be used to provide necessary construction funds to school districts which have urgent construction needs but which lack sufficient resources at present, and cannot reasonably anticipate sufficient resources within the period of the next 3 years, for these purposes from currently authorized sources of capital outlay revenue. A school district requesting funding from the Special Facility Construction Account shall submit one specific construction project, not to exceed one complete educational plant, to the Special Facility Construction Committee. A ~~No~~ district may not ~~shall~~ receive funding for more than one approved project in any 3-year period or while any portion of the district's participation requirement remains outstanding. The first year of the 3-year period shall be the first year a district receives an appropriation. The department shall encourage a construction program that reduces the average size of schools in the district. The request must meet the following criteria to be considered by the committee:

1. The project must be deemed a critical need and must be recommended for funding by the Special Facility Construction Committee. Before ~~Prior to~~ developing construction plans for the proposed facility, the district school board must request a preapplication review by the Special Facility Construction Committee or a project review subcommittee convened by the chair of the committee to include two representatives of the department and two staff members from school districts not eligible to participate in the program. The request for a

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preapplication review may be made at any time; however, for inclusion in the Department of Education's next annual capital outlay legislative budget request, the request for a preapplication review must be made before February 1 of the fiscal year before the legislative budget request. Within 90 ~~60~~ days after receiving the preapplication review request, the committee or subcommittee must meet in the school district to review the project proposal and existing facilities. To determine whether the proposed project is a critical need, the committee or subcommittee shall consider, at a minimum, 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; the district's existing and projected capital outlay full-time equivalent student enrollment as determined by the demographic, revenue, and education estimating conferences established in s. 216.136 ~~department~~; the district's existing satisfactory student stations; the use of all existing district property and facilities; grade level configurations; and any other information that may affect the need for the proposed project.

2. The construction project must be recommended in the most recent survey or survey amendment cooperatively prepared ~~surveys~~ by the district and the department, and approved by the department under the rules of the State Board of Education. If a district employs a consultant in the preparation of a survey or survey amendment, the consultant may not be employed by or

<u>receive compensation from a third party that designs or constructs a project recommended by the survey.</u>

3. The construction project must appear on the district's approved project priority list under the rules of the State Board of Education.

4. The district must have selected and had approved a site for the construction project in compliance with s. 1013.36 and the rules of the State Board of Education.

5. The district shall have developed a district school board adopted list of facilities that do not exceed the norm for net square feet occupancy requirements under the State Requirements for Educational Facilities, using all possible programmatic combinations for multiple use of space to obtain maximum daily use of all spaces within the facility under consideration.

6. Upon construction, the total cost per student station, including change orders, <u>may</u> ~~must~~ not exceed the cost per student station as provided in subsection (6)<u>, except for cost overruns created by a disaster as defined in s. 252.34 or an unforeseeable circumstance beyond the district's control as determined by the Special Facility Construction Committee</u>.

7. There shall be an agreement signed by the district school board stating that it will advertise for bids within 30 days of receipt of its encumbrance authorization from the department.

8. <u>For construction projects for which Special Facility</u>

Construction Account funding is sought before the 2019-2020 fiscal year, the district shall, at the time of the request and for a continuing period necessary to meet the district's participation requirement under subparagraph 11. ~~of 3 years~~, levy the maximum millage against their nonexempt assessed property value as allowed in s. 1011.71(2) or shall raise an equivalent amount of revenue from the school capital outlay surtax authorized under s. 212.055(6). Beginning with the 2019-2020 fiscal year, for construction projects for which Special Facility Construction Account funding is sought, the district shall, for a minimum of 3 years before the request and for a continuing period necessary to meet the district's participation requirement under subparagraph 11., levy the maximum millage against their nonexempt assessed property value as allowed in s. 1011.71(2) or raise an equivalent amount of revenue from the school capital outlay surtax authorized under s. 212.055(6). Any district with a new or active project, funded under the provisions of this subsection, shall be required to budget no more than the value of 1.0 mill ~~1.5 mills~~ per year to the project until the district's ~~to satisfy the annual~~ participation requirement relating to the local discretionary capital improvement millage authorized under s. 1011.71(2) or the equivalent amount of revenue from the school capital outlay surtax authorized under s. 212.055(6) is satisfied ~~in the Special Facility Construction Account~~.

9. If a contract has not been signed 90 days after the

advertising of bids, the funding for the specific project shall revert to the Special Facility New Construction Account to be reallocated to other projects on the list. However, an additional 90 days may be granted by the commissioner.

10. The department shall certify the inability of the district to fund the survey-recommended project over a continuous 3-year period using projected capital outlay revenue derived from s. 9(d), Art. XII of the State Constitution, as amended, paragraph (3)(a) of this section, and s. 1011.71(2).

11. The district shall have on file with the department an adopted resolution acknowledging its ~~3-year~~ commitment to satisfy its participation requirement. The district's participation requirement is equivalent to ~~of~~ all unencumbered and future revenue acquired in the year of the initial appropriation and for the 2 years immediately following the initial appropriation from s. 9(d), Art. XII of the State Constitution, as amended, paragraph (3)(a) of this section, and s. 1011.71(2).

12. Final phase III plans must be certified by the district school board as complete and in compliance with the building and life safety codes before June 1 of the year the application is made ~~prior to August 1~~.

(b) The Special Facility Construction Committee shall be composed of the following: two representatives of the Department of Education, a representative from the Governor's office, a representative selected annually by the district school boards, and a representative selected annually by the superintendents. A representative of the department shall chair the committee.

(6)

(b)1. A district school board may ~~must~~ not use funds from the following sources: Public Education Capital Outlay and Debt Service Trust Fund; School District and Community College District Capital Outlay and Debt Service Trust Fund; Classrooms First Program funds provided in s. 1013.68; nonvoted 1.5-mill levy of ad valorem property taxes provided in s. 1011.71(2); Classrooms for Kids Program funds provided in s. 1013.735; District Effort Recognition Program funds provided in s. 1013.736; and ~~or~~ High Growth District Capital Outlay Assistance Grant Program funds provided in s. 1013.738 for any new construction of educational plant space with a total cost per student station, including change orders, that equals more than:

a. $17,952 for an elementary school,

b. $19,386 for a middle school, or

c. $25,181 for a high school,

(January 2006) as adjusted annually to reflect increases or decreases in the Consumer Price Index.

2. Effective July 1, 2017, in addition to the funding sources listed in subparagraph 1., a district school board may not use funds from the following sources: nonvoted 1.5-mill levy of ad valorem property taxes provided in s. 1011.71(3); proceeds received through the provisions of s. 1011.73 and s. 9, Art. VII

of the State Constitution; funds provided by school district bonds; sales surtax funds authorized in s. 212.055; impact fees authorized in s. 163.31801; and funds received pursuant to s. 212.20(6)(d)6.a., for any new construction of educational plant space with a total cost per student station, including change orders, that equals more than the current adjusted amounts provided in sub-subparagraphs 1.a.-c., which shall subsequently be adjusted annually to reflect increases or decreases in the Consumer Price Index.

3. A district school board may ~~must~~ not use funds from the Public Education Capital Outlay and Debt Service Trust Fund or the School District and Community College District Capital Outlay and Debt Service Trust Fund for any new construction of an ancillary plant that exceeds 70 percent of the average cost per square foot of new construction for all schools.

(c)1. Except as otherwise provided, new construction initiated by a district school board may ~~after June 30, 1997, must~~ not exceed the cost per student station as provided in paragraph (b).

2. New construction initiated by a district school board on or after July 1, 2017, may not exceed the cost per student station provided in paragraph (b). A district that exceeds the cost per student station provided in paragraph (b) is ineligible for allocations from the Public Capital Outlay and Debt Service Trust Fund for the next 3 years in which the district would have received allocations had the violation not occurred.

(d) The department shall:

1. Compute for each calendar year the statewide average construction costs for facilities serving each instructional level, for relocatable educational facilities, for administrative facilities, and for other ancillary and auxiliary facilities. The department shall compute the statewide average costs per student station for each instructional level.

2. Annually review the actual completed construction costs of educational facilities in each school district. For any school district in which the total actual cost per student station, including change orders, exceeds the statewide limits established in paragraph (b), the school district shall report to the department the actual cost per student station and the reason for the school district's inability to adhere to the limits established in paragraph (b). The department shall collect all such reports and shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year a summary of each school district's spending in excess of the cost per student station provided in paragraph (b) as reported by the school districts.

Cost per student station includes contract costs, legal and administrative costs, fees of architects and engineers, furniture and equipment, site costs, ~~and~~ site improvement costs, and offsite 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.

(e) The department shall conduct a study, in consultation with the Office of Economic and Demographic Research, of the total cost per student station amounts under paragraph (b) using the most recent available information. 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 restrictions of this subsection on the cost per student station of new construction do not apply to a project funded entirely from proceeds received by districts through provisions of ss. 212.055 and 1011.73 and s. 9, Art. VII of the State Constitution, if the school board approves the project by majority vote~~.

Section 4. This act shall take effect July 1, 2016.

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HB 965

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 AK	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

A bill to be entitled

An act relating to firesafety; amending s. 429.41, F.S.; requiring the State Fire Marshal to adopt uniform firesafety standards for assisted living facilities; revising provisions relating to the minimum standards that must be adopted by the Department of Elderly Affairs for firesafety in assisted living facilities; providing an effective date.

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

Section 1. Subsection (1) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. <u>The State Fire Marshal shall adopt uniform firesafety standards for assisted living facilities as specified in s.</u>

633.206. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Families, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with chapter 553, relating to plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents ~~and protection from fire hazard, including adequate provisions for fire alarm and other fire protection~~ suitable to the size of the structure. ~~Uniform firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the agency, the department, and the Department of Health.~~

1. Firesafety evacuation capability determination.—

~~a. The National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, shall be used for determining the ability of the residents, with or without staff assistance, to relocate from or within a licensed facility to a point of safety as provided in the fire codes adopted herein.~~ An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. ~~For existing licensed facilities that are not equipped with an automatic fire sprinkler system, the administrator shall evaluate the evacuation capability of residents at least annually. The evacuation capability evaluation for each facility not equipped with an automatic fire sprinkler system shall be validated, without liability, by the State Fire Marshal, by the local fire marshal, or by the local authority having jurisdiction over firesafety, before the license renewal date. If the State Fire Marshal, local fire marshal, or local authority having jurisdiction over firesafety has reason to believe that the evacuation capability of a facility as reported by the administrator may have changed, it may, with assistance from the facility administrator, reevaluate the evacuation capability through timed exiting drills. Translation of timed fire exiting drills to evacuation capability may be determined:~~

~~(I) Three minutes or less: prompt.~~

~~(II) More than 3 minutes, but not more than 13 minutes: slow.~~

~~(III) More than 13 minutes: impractical.~~

~~b. The Office of the State Fire Marshal shall provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the Agency for Health Care Administration who are responsible for regulating facilities under this part, and to local governmental inspectors. The Office of the State~~

~~Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.~~

~~c. The Office of the State Fire Marshal, in cooperation with provider associations, shall provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.~~

~~d. The administrator of a licensed facility shall sign an affidavit verifying the number of residents occupying the facility at the time of the evacuation capability evaluation.~~

2. Firesafety requirements.—

a. ~~Except for the special applications provided herein, effective January 1, 1996,~~ The National Fire Protection Association, Life Safety Code, NFPA 101 <u>and 101A</u>, <u>current editions</u> ~~1994 edition~~, ~~Chapter 22 for new facilities and Chapter 23 for existing facilities~~ shall be <u>used in determining</u> the uniform <u>firesafety</u> ~~fire~~ code <u>adopted</u> ~~applied~~ by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

~~b. Any new facility, regardless of size, that applies for a license on or after January 1, 1996, must be equipped with an automatic fire sprinkler system. The exceptions as provided in s. 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply to any new facility housing eight or fewer residents. On July 1, 1995, local governmental entities responsible for the issuance of permits for construction shall inform, without liability, any facility whose permit for construction is obtained before January 1, 1996, of this automatic fire sprinkler requirement. As used in this part, the term "a new facility" does not mean an existing facility that has undergone change of ownership.~~

~~c. Notwithstanding any provision of s. 633.206 or of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, to the contrary, any existing facility housing eight or fewer residents is not required to install an automatic fire sprinkler system, nor to comply with any other requirement in Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety requirements of NFPA 101, 1988 edition, that applies to this size facility, unless the facility has been classified as impractical to evacuate. Any existing facility housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes granted in this section.~~

~~d. Any existing facility that is required to install an automatic fire sprinkler system under this paragraph need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994~~

~~edition, which exceed the provisions of NFPA 101, 1988 edition. The mandate contained in this paragraph which requires certain facilities to install an automatic fire sprinkler system supersedes any other requirement.~~

~~e. This paragraph does not supersede the exceptions granted in NFPA 101, 1988 edition or 1994 edition.~~

~~f. This paragraph does not exempt facilities from other firesafety provisions adopted under s. 633.206 and local building code requirements in effect before July 1, 1995.~~

b.~~g.~~ A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in an existing and properly licensed assisted living facility structure ~~as of January 1, 1996~~.

~~h. If a licensed facility undergoes major reconstruction or addition to an existing building on or after January 1, 1996, the entire building must be equipped with an automatic fire sprinkler system. Major reconstruction of a building means repair or restoration that costs in excess of 50 percent of the value of the building as reported on the tax rolls, excluding land, before reconstruction. Multiple reconstruction projects within a 5-year period the total costs of which exceed 50 percent of the initial value of the building when the first reconstruction project was permitted are to be considered as major reconstruction. Application for a permit for an automatic~~

~~fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50-percent threshold.~~

~~i. Any facility licensed before January 1, 1996, that is required to install an automatic fire sprinkler system shall ensure that the installation is completed within the following timeframes based upon evacuation capability of the facility as determined under subparagraph 1.:~~

~~(I) Impractical evacuation capability, 24 months.~~

~~(II) Slow evacuation capability, 48 months.~~

~~(III) Prompt evacuation capability, 60 months.~~

~~The beginning date from which the deadline for the automatic fire sprinkler installation requirement must be calculated is upon receipt of written notice from the local fire official that an automatic fire sprinkler system must be installed. The local fire official shall send a copy of the document indicating the requirement of a fire sprinkler system to the Agency for Health Care Administration.~~

~~j. It is recognized that the installation of an automatic fire sprinkler system may create financial hardship for some facilities. The appropriate local fire official shall, without liability, grant two 1-year extensions to the timeframes for installation established herein, if an automatic fire sprinkler installation cost estimate and proof of denial from two financial institutions for a construction loan to install the~~

~~automatic fire sprinkler system are submitted. However, for any facility with a class I or class II, or a history of uncorrected class III, firesafety deficiencies, an extension must not be granted. The local fire official shall send a copy of the document granting the time extension to the Agency for Health Care Administration.~~

~~k. A facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, as adopted herein, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists. The sale of the facility does not alter the timeframe for the installation of the automatic fire sprinkler system.~~

~~l. Existing facilities required to install an automatic fire sprinkler system as a result of construction-type restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted herein, or evacuation capability requirements shall be notified by the local fire official in writing of the automatic fire sprinkler requirement, as well as the appropriate date for final compliance as provided in this subparagraph. The local fire official shall send a copy of the document to the Agency for Health Care Administration.~~

~~m. Except in cases of life-threatening fire hazards, if an existing facility experiences a change in the evacuation capability, or if the local authority having jurisdiction identifies a construction-type restriction, such that an~~

~~automatic fire sprinkler system is required, it shall be given time for installation as provided in this subparagraph.~~

~~Facilities that are fully sprinkled and in compliance with other firesafety standards are not required to conduct more than one of the required fire drills between the hours of 11 p.m. and 7 a.m., per year. In lieu of the remaining drills, staff responsible for residents during such hours may be required to participate in a mock drill that includes a review of evacuation procedures. Such standards must be included or referenced in the rules adopted by the State Fire Marshal. Pursuant to s. 633.206(1)(b), the State Fire Marshal is the final administrative authority for firesafety standards established and enforced pursuant to this section.~~

c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the department after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.

(e) License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(f) Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties, and use of income from fees and fines.

(g) The enforcement of the resident bill of rights specified in s. 429.28.

(h) The care and maintenance of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services,

as needed by residents;

5. The management of medication;

6. The nutritional needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(i) Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(k) The use of physical or chemical restraints. The use of physical restraints is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.

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

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Harrison offered the following:

Amendment (with title amendment)

Remove lines 25-26 and insert:

facility. Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s.

Between lines 225 and 226, insert:

d. An assisted living facility licensed before July 1, 2016, is exempt from any requirement in the uniform firesafety code established and adopted pursuant to s. 633.206 by the State Fire Marshal for assisted living facilities which exceeds the firesafety requirements of NFPA 101, 1994 edition, Chapter 23, Existing Residential Board and Care Occupancies. However, a facility that undergoes building rehabilitation as described by the uniform firesafety code established by the State Fire

Marshal must thereafter be in compliance with the uniform firesafety code in effect for assisted living facilities under sub-subparagrah a.

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

Remove line 8 and insert:

assisted living facilities; providing an exemption for existing assisted living facilities under certain 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

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[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

A bill to be entitled

An act relating to implementation of the water and land conservation constitutional amendment; amending s. 375.041, F.S.; requiring a minimum specified percentage of funds within the Land Acquisition Trust Fund to be appropriated for Everglades restoration projects; providing a preference in the use of funds to certain projects that reduce discharges to the St. Lucie and Caloosahatchee estuaries; providing an effective date.

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

Section 1. Subsection (3) of section 375.041, Florida Statutes, is amended to read:

375.041 Land Acquisition Trust Fund.—

(3) Funds distributed into the Land Acquisition Trust Fund pursuant to s. 201.15 shall be applied:

(a) 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; <u>and</u>

(b) <u>Of the funds remaining after the payments required under paragraph (a) but before funds may be appropriated or</u>

dedicated for other uses, a minimum of the lesser of 25 percent or $200 million shall be appropriated annually for Everglades projects that implement the Comprehensive Everglades Restoration Plan as set forth in s. 373.470, including the Central Everglades Planning Project subject to congressional authorization; the Long-Term Plan as defined in s. 373.4592(2); and the Northern Everglades and Estuaries Protection Program as set forth in s. 373.4595. From these funds, $32 million shall be distributed each fiscal year through the 2023-2024 fiscal year to the South Florida Water Management District for the Long-Term Plan as defined in s. 373.4592(2). After deducting the $32 million distributed under this paragraph, from the funds remaining, a minimum of the lesser of 76.5 percent or $100 million shall be appropriated each fiscal year through the 2025-2026 fiscal year for the planning, design, engineering, and construction of the Comprehensive Everglades Restoration Plan as set forth in s. 373.470, including the Central Everglades Planning Project subject to congressional authorization. The Department of Environmental Protection and the South Florida Water Management District shall give preference to those Everglades restoration projects that reduce harmful discharges of water from Lake Okeechobee to the St. Lucie or Caloosahatchee estuaries in a timely manner ~~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~~

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

~~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~~

~~(c) 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~~.

Section 2. This act shall take effect July 1, 2016.

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

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 JKD	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

[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

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

[21] *Id.*

A bill to be entitled

An act relating to emergency management; amending s. 252.34, F.S.; defining the term "activate" for purposes of part I of ch. 252, F.S.; amending ss. 163.360, 474.2125, and 627.659, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (1) through (9) of section 252.34, Florida Statutes, are renumbered as subsections (2) through (10), respectively, and a new subsection (1) is added to that section, to read:

252.34 Definitions.—As used in this part, the term:

<u>(1) "Activate" means 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.</u>

Section 2. Subsection (10) of section 163.360, Florida Statutes, is amended to read:

163.360 Community redevelopment plans.—

(10) Notwithstanding any other provisions of this part, when the governing body certifies that an area is in need of redevelopment or rehabilitation as a result of an emergency

under s. 252.34(4) ~~s. 252.34(3)~~, with respect to which the Governor has certified the need for emergency assistance under federal law, that area may be certified as a "blighted area," and the governing body may approve a community redevelopment plan and community redevelopment with respect to such area without regard to the provisions of this section requiring a general plan for the county or municipality and a public hearing on the community redevelopment.

Section 3. Subsection (1) of section 474.2125, Florida Statutes, is amended to read:

474.2125 Temporary license.—

(1) The board shall adopt rules providing for the issuance of a temporary license to a licensed veterinarian of another state for the purpose of enabling her or him to provide veterinary medical services in this state for the animals of a specific owner or, as may be needed in an emergency as defined in s. 252.34(4) ~~s. 252.34(3)~~, for the animals of multiple owners, provided the applicant would qualify for licensure by endorsement under s. 474.217. No temporary license shall be valid for more than 30 days after its issuance, and no license shall cover more than the treatment of the animals of one owner except in an emergency as defined in s. 252.34(4) ~~s. 252.34(3)~~. After the expiration of 30 days, a new license is required.

Section 4. Subsection (4) of section 627.659, Florida Statutes, is amended to read:

627.659 Blanket health insurance; eligible groups.—Blanket health insurance is that form of health insurance which covers special groups of individuals as enumerated in one of the following subsections:

(4) Under a policy or contract issued in the name of a volunteer fire department, first aid group, local emergency management agency as defined in s. 252.34(6) ~~s. 252.34(5)~~, or other group of first responders as defined in s. 112.1815, which is deemed the policyholder, covering all or any grouping of the members or employees of the policyholder or covering all or any participants in an activity or operation sponsored or supervised by the policyholder.

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 DmP	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:

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[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.

A bill to be entitled

An act relating to duties of the Legislative Auditing Committee; amending s. 11.45, F.S.; removing a requirement that the Auditor General notify the committee regarding certain financial or operational audit reports of state universities or Florida College System institutions; removing duties of the committee relating to state universities or Florida College System institutions that have failed to take corrective action based on such reports; amending s. 215.985, F.S.; repealing provisions requiring the committee's input related to the website of the Executive Office of the Governor; amending s. 1002.395, F.S.; correcting a cross-reference; providing an effective date.

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

Section 1. Paragraph (j) of subsection (7) of section 11.45, Florida Statutes, is amended to read:

11.45 Definitions; duties; authorities; reports; rules.—

(7) AUDITOR GENERAL REPORTING REQUIREMENTS.—

(j) The Auditor General shall notify the Legislative Auditing Committee of any financial or operational audit report prepared pursuant to this section which 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.

1. The committee may direct the district school board ~~or the governing body of the state university or Florida College System institution~~ to provide a written statement to the committee explaining why full corrective action has not been taken or, if the district school board ~~governing body~~ intends to take full corrective action, describing the corrective action to be taken and when it will occur.

2. If the committee determines that the written statement is not sufficient, the committee may require the chair of the district school board ~~or the chair of the governing body of the state university or Florida College System institution,~~ or the chair's designee~~,~~ to appear before the committee.

3. If the committee determines that the district school board~~, state university, or Florida College System institution~~ has failed to take full corrective action for which there is no justifiable reason or has failed to comply with committee requests made pursuant to this section, the committee shall refer the matter to the State Board of Education ~~or the Board of Governors, as appropriate,~~ to proceed in accordance with s. 1008.32 ~~or s. 1008.322, respectively~~.

Section 2. Subsections (2), (7), (8), (9), and (13) of section 215.985, Florida Statutes, are amended to read:

215.985 Transparency in government spending.—

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

~~(a) "Committee" means the Legislative Auditing Committee created in s. 11.40.~~

(a) ~~(b)~~ "Contract" means a written agreement or purchase order issued for the purchase of goods or services or a written agreement for the receipt of state or federal financial assistance.

(b) ~~(c)~~ "Governmental entity" means a state, regional, county, municipal, special district, or other political subdivision whether executive, judicial, or legislative, including, but not limited to, a department, division, bureau, commission, authority, district, or agency thereof, or public school, Florida College System institution, state university, or associated board.

(c) ~~(d)~~ "Website" means a site on the Internet which is easily accessible to the public at no cost and does not require the user to provide information.

~~(7) By November 1, 2013, and annually thereafter, the committee shall recommend to the President of the Senate and the Speaker of the House of Representatives:~~

~~(a) 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 districts, charter schools, charter technical career centers, local government units, and other governmental entities.~~

~~(b) A schedule for adding information to the website by type of information and governmental entity, including timeframes and development entity.~~

~~(c) A format for collecting and displaying the additional information.~~

~~(8) The manager of each website described in subsections (4), (5), and (6) shall submit to the committee information relating to the cost of creating and maintaining such website, and the number of times the website has been accessed.~~

~~(9) The committee shall coordinate with the Financial Management Information Board in developing recommendations for including information on the website which is necessary to meet the requirements of s. 215.91(8).~~

~~(13) The committee shall prepare an annual 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 shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1.~~

Section 3. Paragraph (d) of subsection (9) of section 1002.395, Florida Statutes, is amended to read:

1002.395 Florida Tax Credit Scholarship Program.—

(9) DEPARTMENT OF EDUCATION OBLIGATIONS.—The Department of Education shall:

(d) Annually verify the eligibility of expenditures as provided in paragraph (6)(d) using the audit required by paragraph (6)(m) and s. 11.45(2)(j) ~~11.45(2)(k)~~.

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 $14 | $60 | $100 Mail Order	$7 | $30 | $50 Retail $14 | $60 | $100 Mail Order	Pay in full, file claim
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.

[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.

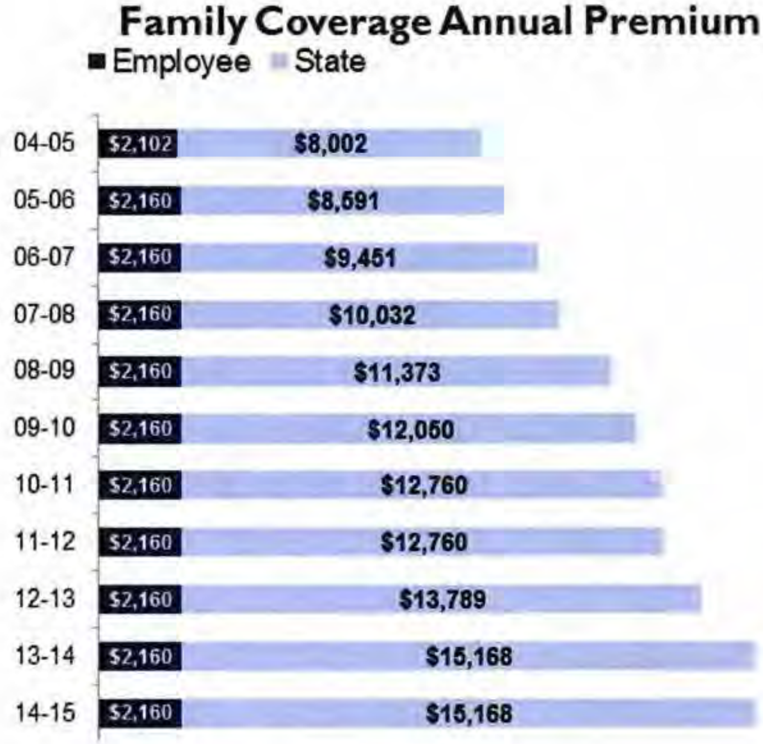
[16] Department of Management Services, State Employees' Group Health Self-Insurance Trust Fund, *Premium Rate Table Effective December 2015 for January 2016 Coverage,* available at http://mybenefits.myflorida.com/content/download/118950/652870/DSGI_-_Premium_Table_Effective_December_2015_for_January_2016_Coverage.pdf (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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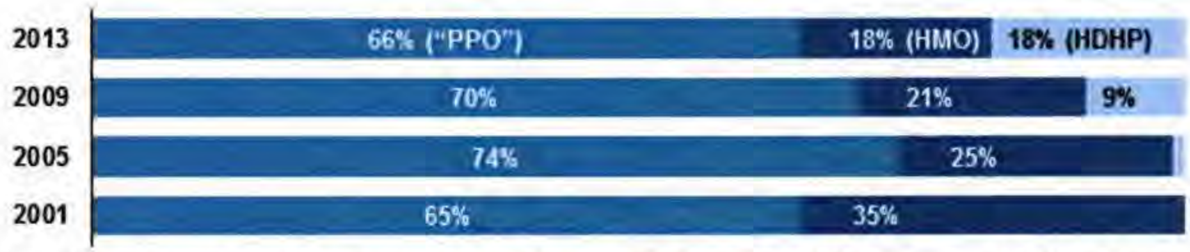
[19] Supra, FN 2, page 1.
[20] Id.
[21] Id. at page 2.
[22] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, State Employees' Group Health Self-Insurance Trust Fund, *Report on the Financial Outlook*, March 9, 2015, page 1, available at http://edr.state.fl.us/Content/conferences/healthinsurance/archives/150309healthins.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

[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

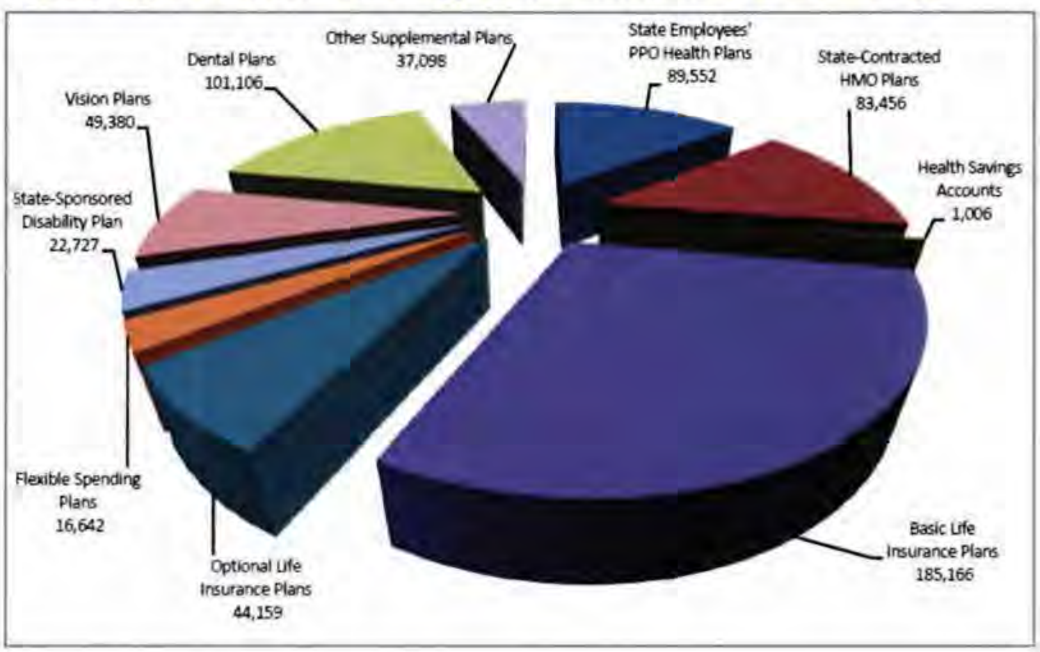
Current law provides that "the state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees . . .participating in the same coverage tier[37] in the same plan."[38] Since there is a 4 percent difference in the actuarial value 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:

Insurance Plans Average Enrollment FY 2011-12



[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

A bill to be entitled

An act relating to the state group insurance program; amending s. 110.123, F.S.; revising applicability of certain definitions; defining the term "plan year"; authorizing the program to include additional benefits; authorizing an employee to use a specified portion of the state's contribution to purchase additional program benefits and supplemental benefits under certain circumstances; providing for the program to offer health plans in specified benefit levels; requiring the Department of Management Services to develop a plan for implementation of the benefit levels; providing reporting requirements; providing for expiration of the implementation plan; creating s. 110.12303, F.S.; authorizing additional benefits to be included in the program; requiring the department to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures; providing contract and reporting requirements; requiring the department to contract with an entity to provide enrollees with online information on health care services and providers; providing contract and reporting requirements; creating s. 110.12304, F.S.; directing the department to contract with an independent benefits consultant; providing qualifications and duties of the independent benefits consultant; providing reporting requirements; providing that the department shall determine and recommend premiums for enrollees for the 2017 plan year; providing requirements for the determination of premiums; requiring the department to submit premium rates to the Legislative Budget Commission by a specified date for review and approval; requiring premium rates to be consistent with the total budgeted amount for the program in the General Appropriations Act for the 2016-2017 fiscal year; providing an appropriation and authorizing positions; providing an effective date.

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

Section 1. Subsection (2) and paragraphs (b), (f), (h), and (j) of subsection (3) of section 110.123, Florida Statutes, are amended, and paragraph (k) is added to subsection (3) of that section, to read:

110.123 State group insurance program.—

(2) DEFINITIONS.—As used in ss. 110.123-110.1239 ~~this section~~, the term:

(a) "Department" means the Department of Management Services.

(b) "Enrollee" means all state officers and employees, retired state officers and employees, surviving spouses of deceased state officers and employees, and terminated employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program. "Enrollee" includes all state university officers and employees, retired state university officers and employees, surviving spouses of deceased state university officers and employees, and terminated state university employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program.

(c) "Full-time state employees" means employees of all branches or agencies of state government holding salaried positions who are paid by state warrant or from agency funds and who work or are expected to work an average of at least 30 or more hours per week; employees paid from regular salary appropriations for 8 months' employment, including university personnel on academic contracts; and employees paid from other-personal-services (OPS) funds as described in subparagraphs 1. and 2. The term includes all full-time employees of the state universities. The term does not include seasonal workers who are paid from OPS funds.

1. For persons hired before April 1, 2013, the term includes any person paid from OPS funds who:

a. Has worked an average of at least 30 hours or more per week during the initial measurement period from April 1, 2013, through September 30, 2013; or

b. Has worked an average of at least 30 hours or more per week during a subsequent measurement period.

2. For persons hired after April 1, 2013, the term includes any person paid from OPS funds who:

a. Is reasonably expected to work an average of at least 30 hours or more per week; or

b. Has worked an average of at least 30 hours or more per week during the person's measurement period.

(d) "Health maintenance organization" or "HMO" means an entity certified under part I of chapter 641.

(e) "Health plan member" means any person participating in a state group health insurance plan, a TRICARE supplemental insurance plan, or a health maintenance organization plan under the state group insurance program, including enrollees and covered dependents thereof.

(f) "Part-time state employee" means an employee of any branch or agency of state government paid by state warrant from salary appropriations or from agency funds, and who is employed for less than an average of 30 hours per week or, if on academic contract or seasonal or other type of employment which is less than year-round, is employed for less than 8 months during any 12-month period, but does not include a person paid from other-personal-services (OPS) funds. The term includes all part-time employees of the state universities.

<u>(g) "Plan year" means a calendar year.</u>

<u>(h)</u>~~(g)~~ "Retired state officer or employee" or "retiree"

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means any state or state university officer or employee who retires under a state retirement system or a state optional annuity or retirement program or is placed on disability retirement, and who was insured under the state group insurance program at the time of retirement, and who begins receiving retirement benefits immediately after retirement from state or state university office or employment. The term also includes any state officer or state employee who retires under the Florida Retirement System Investment Plan established under part II of chapter 121 if he or she:

1. Meets the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29); or

2. Has attained the age specified by s. 72(t)(2)(A)(i) of the Internal Revenue Code and has 6 years of creditable service.

(i)~~(h)~~ "State agency" or "agency" means any branch, department, or agency of state government. "State agency" or "agency" includes any state university for purposes of this section only.

(j)~~(i)~~ "Seasonal workers" has the same meaning as provided under 29 C.F.R. s. 500.20(s)(1).

(k)~~(j)~~ "State group health insurance plan or plans" or "state plan or plans" mean the state self-insured health insurance plan or plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section.

(l)~~(k)~~ "State-contracted HMO" means any health maintenance organization under contract with the department to participate in the state group insurance program.

(m) ~~(l)~~ "State group insurance program" or "programs" means the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan or plans, health maintenance organization plans, TRICARE supplemental insurance plans, and other plans required or authorized by law.

(n) ~~(m)~~ "State officer" means any constitutional state officer, any elected state officer paid by state warrant, or any appointed state officer who is commissioned by the Governor and who is paid by state warrant.

(o) ~~(n)~~ "Surviving spouse" means the widow or widower of a deceased state officer, full-time state employee, part-time state employee, or retiree if such widow or widower was covered as a dependent under the state group health insurance plan, ~~a~~ TRICARE supplemental insurance plan, or a health maintenance organization plan established pursuant to this section at the time of the death of the deceased officer, employee, or retiree. "Surviving spouse" also means any widow or widower who is receiving or eligible to receive a monthly state warrant from a state retirement system as the beneficiary of a state officer, full-time state employee, or retiree who died prior to July 1, 1979. For the purposes of this section, any such widow or widower shall cease to be a surviving spouse upon his or her remarriage.

(p) ~~(o)~~ "TRICARE supplemental insurance plan" means the Department of Defense Health Insurance Program for eligible members of the uniformed services authorized by 10 U.S.C. s. 1097.

(3) STATE GROUP INSURANCE PROGRAM.—

(b) It is the intent of the Legislature to offer a comprehensive package of health insurance and retirement benefits and a personnel system for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs. ~~Therefore,~~ The state group insurance program ~~is established which~~ may include the state group health insurance plan or plans, health maintenance organization plans, group life insurance plans, TRICARE supplemental insurance plans, group accidental death and dismemberment plans, ~~and~~ group disability insurance plans, ~~. Furthermore, the department is additionally authorized to establish and provide as part of the state group insurance program any~~ other group insurance plans or coverage choices, and other benefits authorized by law ~~that are consistent with the provisions of this section~~.

(f) Except as provided for in subparagraph (h)2., the state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees in a state collective bargaining unit participating in the same coverage tier in the same plan. This section does not prohibit the development of separate benefit plans for officers and employees exempt from the career service or the development of separate benefit plans for each collective bargaining unit. For the 2019 plan year and thereafter, if the state's contribution is more than the premium cost of the health plan selected by the employee, subject to federal limitation, the employee may elect to have the balance:

1. Credited to the employee's flexible spending account;

2. Credited to the employee's health savings account;

3. Used to purchase additional benefits offered through the state group insurance program; or

4. Used to increase the employee's salary.

(h)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group

insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; age-based and gender-based wellness benefits; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO. As used in this paragraph, the term "age-based and gender-based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education, smoking cessation, stress management, weight management, and women's health education.

b. The department may establish uniform deductibles, copayments, coverage tiers, or coinsurance schedules for all participating HMO plans.

c. The department may require detailed information from

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each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the department determines that the plan offers high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the department receives, the number of state employees in the service area, or any unique geographical characteristics of the service area. The department shall establish by rule service areas throughout the state.

e. All persons participating in the state group insurance program may be required to contribute towards a total state group health premium that may vary depending upon the plan, coverage level, and coverage tier selected by the enrollee and the level of state contribution authorized by the Legislature.

3. The department is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department may enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25-percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a.-d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal or invitation to negotiate process described in subparagraph 2.

5. All enrollees in a state group health insurance plan, a TRICARE supplemental insurance plan, or any health maintenance organization plan have the option of changing to any other health plan that is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after

termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the department shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to

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select from among benefit options that best suit their individual and family needs. Beginning with the 2017 plan year, the package of benefits may also include products and services described in s. 110.12303.

a. Based upon a desired benefit package, the department shall issue a request for proposal or invitation to negotiate for ~~health insurance~~ providers interested in participating in the state group insurance program, and the department shall issue a request for proposal or invitation to negotiate for ~~insurance~~ providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with ~~insurance~~ providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, except as provided in subparagraph (f)3., no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental ~~insurance~~ benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

(j) <u>For the 2019 plan year and thereafter, health plans shall be offered in the following benefit levels:</u>

<u>1. Platinum level, which shall have an actuarial value of at least 90 percent.</u>

<u>2. Gold level, which shall have an actuarial value of at least 80 percent.</u>

<u>3. Silver level, which shall have an actuarial value of at least 70 percent.</u>

4. Bronze level, which shall have an actuarial value of at least 60 percent ~~Notwithstanding paragraph (f) requiring uniform contributions, and for the 2011-2012 fiscal year only, the state contribution toward the cost of any plan in the state group insurance plan is the difference between the overall premium and the employee contribution. This subsection expires June 30, 2012~~.

(k) In consultation with the independent benefits consultant described in s. 110.12304, the department shall develop a plan for implementation of the benefit levels described in paragraph (j). The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2018, and include recommendations for:

1. Employer and employee contribution policies.

2. Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.

3. An education strategy to inform employees of the additional choices available in the state group insurance program.

This paragraph expires July 1, 2018.

Section 2. Section 110.12303, Florida Statutes, is created to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—Beginning with the 2017 plan year:

(1) In addition to the comprehensive package of health insurance and other benefits required or authorized to be included in the state group insurance program, the package of benefits may also include products and services offered by:

(a) Prepaid limited health service organizations authorized pursuant to part I of chapter 636.

(b) Discount medical plan organizations authorized pursuant to part II of chapter 636.

(c) Prepaid health clinics licensed under part II of chapter 641.

(d) Licensed health care providers, including hospitals and other health facilities, health care clinics, and health professionals, who sell service contracts and arrangements for a specified amount and type of health services.

(e) 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.

(f) 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.

(g) Entities that provide health services or treatments through a bidding process.

(h) Entities that provide health services or treatments through the bundling or aggregating of health services or treatments.

(i) Entities that provide other innovative and cost-effective health service delivery methods.

(2)(a) The department shall contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures which may be accessed at the option of the enrollee. The contract shall require the entity to:

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.

2. Provide assistance to the enrollee in accessing and coordinating care.

3. Provide cost savings to the state group insurance program to be shared with both the state and the enrollee. Cost savings payable to an enrollee may be:

a. Credited to the enrollee's flexible spending account;

b. Credited to the enrollee's health savings account;

c. Credited to the enrollee's health reimbursement account; or

d. Paid as additional health plan reimbursements not exceeding the amount of the employee's out-of-pocket medical expenses.

4. Provide an educational campaign for enrollees to learn about the services offered by the entity.

(b) On or before January 15 of each year, the department shall 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 the contract or contracts described in this subsection.

(3) The department shall contract with an entity that provides enrollees with online information on the cost and quality of health care services and providers, allows an enrollee to shop for health care services and providers, and rewards the enrollee by sharing any savings generated by the enrollee's choice of services or providers. The contract shall require the entity to:

(a) Establish an Internet-based, consumer-friendly platform that educates and informs enrollees about the price and quality of health care services and providers, including the average amount paid in each county for health care services and providers. The average amounts paid for such services and providers may be expressed for service bundles, which include all products and services associated with a particular treatment or episode of care, or for separate and distinct products and services.

(b) Allow enrollees to shop for health care services and providers using the price and quality information provided on the Internet-based platform.

(c) Identify the savings realized to the enrollee and state if the enrollee chooses high-quality, lower-cost health care services or providers, and facilitate a shared savings payment to the enrollee. The amount of shared savings shall be determined by a methodology approved by the department and shall maximize value-based purchasing by enrollees. The amount payable to the enrollee may be:

1. Credited to the enrollee's flexible spending account;

2. Credited to the enrollee's health savings account;

3. Credited to the enrollee's health reimbursement account; or

4. Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

(d) On or before 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, amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the implementation of this subsection.

Section 3. Section 110.12304, Florida Statutes, is created to read:

110.12304 Independent benefits consultant.—

(1) The department shall competitively procure an independent benefits consultant.

(2) The independent benefits consultant may not:

(a) Be owned or controlled by a health maintenance

<u>organization or insurer.</u>

<u>(b) Have an ownership interest in a health maintenance organization or insurer.</u>

<u>(c) Have a direct or indirect financial interest in a health maintenance organization or insurer.</u>

<u>(3) The independent benefits consultant must have substantial experience in consultation and design of employee benefit programs for large employers and public employers, including experience with plans that qualify as cafeteria plans under s. 125 of the Internal Revenue Code of 1986.</u>

<u>(4) The independent benefits consultant shall:</u>

<u>(a) Provide an ongoing assessment of trends in benefits and employer-sponsored insurance that affect the state group insurance program.</u>

<u>(b) Conduct a comprehensive analysis of the state group insurance program, including available benefits, coverage options, and claims experience.</u>

<u>(c) Identify and establish appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.</u>

<u>(d) Assist the department with the submission of any necessary plan revisions for federal review.</u>

<u>(e) Assist the department in ensuring compliance with applicable federal and state regulations.</u>

<u>(f) Assist the department in monitoring the adequacy of funding and reserves for the state self-insured plan.</u>

(g) Assist the department in preparing recommendations for any modifications to the state group insurance program which shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1 of each year.

Section 4. For the 2017 plan year, the Department of Management Services shall determine and recommend premiums for enrollees that reflect the actual differences in costs to the program for each of the health maintenance organization and the preferred provider organization plan options offered in the state group insurance program for both self-insured and fully insured plans. The premium alternatives for the plan options shall reflect the costs to the program for both medical and prescription drug benefits. By July 1, 2016, the department shall submit the proposed enrollee premium rates for the 2017 plan year to the Legislative Budget Commission for review and approval. If the Legislative Budget Commission does not approve the proposed rates, the rates provided in the 2016-2017 General Appropriations Act shall apply. The premium rates for employers shall be the same as those established for the state group insurance program in the General Appropriations Act for the 2016-2017 fiscal year.

Section 5. (1) For the 2016-2017 fiscal year, the sums of $151,216 in recurring funds and $507,546 in nonrecurring funds are appropriated from the State Employees Health Insurance Trust Fund to the Department of Management Services, and two full-time equivalent positions and associated salary rate of 120,000 are authorized, for the purpose of implementing this act.

(2)(a) The recurring funds appropriated in this section shall be allocated to the following specific appropriation categories within the Insurance Benefits Administration Program: $150,528 in Salaries and Benefits and $688 in Special Categories Transfer to Department of Management Services—Human Resources Purchased per Statewide Contract.

(b) The nonrecurring funds appropriated in this section shall be allocated to the following specific appropriation categories: $500,000 in Special Categories Contracted Services and $7,546 in Expenses.

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.

A bill to be entitled

An act relating to juror costs; amending s. 28.35, F.S.; revising the list of court-related functions that clerks may fund from filing fees, service charges, costs, and fines; amending s. 40.24, F.S.; conforming provisions to changes made by the act; amending s. 40.29, F.S.; requiring the clerk to forward quarterly estimates on certain jury-related costs to the Justice Administrative Commission; revising procedures governing the payment of certain costs; amending s. 40.31, F.S.; authorizing the commission to apportion funds for specified jury-related costs in certain circumstances; providing for issuance to jurors of certificates for the amount of compensation still due in certain circumstances; amending s. 40.32, F.S.; conforming provisions to changes made by the act; amending s. 40.33, F.S.; authorizing the clerk to make requests to the commission for additional funds to pay certain costs in the event of a deficiency; amending s. 40.34, F.S.; requiring the clerk to provide for payroll in triplicate for the payment of jurors; requiring the clerk to forward a specified number of copies of juror payrolls to the commission by a specified date; requiring the commission to audit such payrolls; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 28.35, Florida Statutes, is amended to read:

28.35 Florida Clerks of Court Operations Corporation.—

(3)(a) The list of court-related functions that clerks may fund from filing fees, service charges, costs, and fines is limited to those functions expressly authorized by law or court rule. Those functions include the following: case maintenance; records management; court preparation and attendance; processing the assignment, reopening, and reassignment of cases; processing of appeals; collection and distribution of fines, fees, service charges, and court costs; processing of bond forfeiture payments; ~~payment of jurors and witnesses; payment of expenses for meals or lodging provided to jurors;~~ data collection and reporting; processing of jurors; determinations of indigent status; and paying reasonable administrative support costs to enable the clerk of the court to carry out these court-related functions.

Section 2. Subsections (3), (4), and (5) of section 40.24, Florida Statutes, are amended to read:

40.24 Compensation and reimbursement policy.—

(3)(a) Jurors who are regularly employed and who continue to receive regular wages while serving as a juror are not entitled to receive compensation from the <u>state</u> ~~clerk of the~~

~~circuit court~~ for the first 3 days of juror service.

(b) Jurors who are not regularly employed or who do not continue to receive regular wages while serving as a juror are entitled to receive $15 per day for the first 3 days of juror service.

(4) Each juror who serves more than 3 days is entitled to be paid by the <u>state</u> ~~clerk of the circuit court~~ for the fourth day of service and each day thereafter at the rate of $30 per day of service.

(5) Jurors are not entitled to additional reimbursement by the <u>state</u> ~~clerk of the circuit court~~ for travel or other out-of-pocket expenses.

Section 3. Section 40.29, Florida Statutes, is amended to read:

40.29 Payment of due-process costs.—

(1)<u>(a)</u> Each clerk of the circuit court, on behalf of the state attorney, private court-appointed counsel, the public defender, and the criminal conflict and civil regional counsel, shall forward to the Justice Administrative Commission, by county, a quarterly estimate of funds necessary to pay for ordinary witnesses, including, but not limited to, witnesses in civil traffic cases and witnesses of the state attorney, the public defender, criminal conflict and civil regional counsel, private court-appointed counsel, and persons determined to be indigent for costs. Each quarter of the state fiscal year, the commission, based upon the estimates, shall advance funds to each clerk to pay for these ordinary witnesses from state funds specifically appropriated for the payment of ordinary witnesses.

(b) Each clerk of the circuit court shall forward to the Justice Administrative Commission a quarterly estimate of funds necessary to pay compensation to jurors and for meals or lodging provided to jurors.

(2) Upon receipt of an estimate pursuant to subsection (1), the Justice Administrative Commission shall endorse the amount deemed necessary for payment by the clerk of the court during the quarterly fiscal period and shall submit a request for payment to the Chief Financial Officer.

(3) Upon receipt of the funds from the Chief Financial Officer, the clerk of the court shall pay all invoices approved and submitted by the state attorney, the public defender, the clerk of the court, criminal conflict and civil regional counsel, and private court-appointed counsel for the items enumerated in subsection (1).

(4) After review for compliance with applicable rates and requirements, the Justice Administrative Commission shall pay all due process service related invoices, except those enumerated in subsection (1), approved and submitted by the state attorney, the public defender, the clerk of the court, criminal conflict and civil regional counsel, or private court-appointed counsel in accordance with the applicable requirements of ss. 29.005, 29.006, and 29.007.

Section 4. Section 40.31, Florida Statutes, is amended to read:

40.31 Justice Administrative Commission; apportionment of funds; insufficient appropriations ~~may apportion appropriation~~.—

(1) If the Justice Administrative Commission has reason to believe that the amount appropriated by the Legislature is insufficient to meet the expenses of witnesses during the remaining part of the state fiscal year, the commission may apportion the money in the treasury for that purpose among the several counties, basing such apportionment upon the amount expended for the payment of witnesses in each county during the prior fiscal year. In such case, each county shall be paid by warrant, issued by the Chief Financial Officer, only the amount so apportioned to each county, and, when the amount so apportioned is insufficient to pay in full all the witnesses during a quarterly fiscal period, the clerk of the court shall apportion the money received pro rata among the witnesses entitled to pay and shall give to each witness a certificate of the amount of compensation still due, which certificate shall be held by the commission as other demands against the state.

(2) If the Justice Administrative Commission has reason to believe that the amount appropriated by the Legislature is insufficient to meet expenses relating to compensation of jurors and meals and lodging provided to jurors during the remaining part of the state fiscal year, the commission may apportion the money in the treasury for those purposes among the several counties, basing such apportionment upon the amount expended for

such purposes in each county during the prior fiscal year. In such case, each county shall be paid by warrant, issued by the Chief Financial Officer, only the amount so apportioned to each county. When the amount so apportioned is insufficient to pay in full all jury-related expenses described herein during a quarterly fiscal period, the clerk of the court shall pay jurors entitled to pay before reimbursing any other jury-related expenses described herein. If the amount so apportioned is insufficient to pay in full all jurors during a quarterly fiscal period, the clerk of the court shall apportion the money received pro rata among the jurors entitled to pay and shall give to each juror a certificate of the amount of compensation still due, which certificate shall be held by the commission as other demands against the state.

Section 5. Section 40.32, Florida Statutes, is amended to read:

40.32 Clerks to disburse money; payments to jurors and witnesses.—

(1) All moneys drawn from the treasury under ~~the provisions of~~ this chapter by the clerk of the court shall be disbursed by the clerk of the court as far as needed in payment of jurors and witnesses, except for expert witnesses paid under a contract or other professional services agreement pursuant to ss. 29.004, 29.005, 29.006, and 29.007, for the legal compensation for service during the quarterly fiscal period for which the moneys were drawn and for no other purposes.

~~(2) The payment of jurors and the payment of expenses for meals and lodging for jurors under the provisions of this chapter are court-related functions that the clerk of the court shall fund from filing fees, service charges, court costs, and fines.~~

<u>(2)</u>~~(3)~~ Jurors and witnesses shall be paid by the clerk of the court in cash, by check, or by warrant within 20 days after completion of jury service or completion of service as a witness.

(a) If the clerk of the court pays a juror or witness by cash, the juror or witness shall sign the payroll in the presence of the clerk, a deputy clerk, or some other person designated by the clerk.

(b) If the clerk pays a juror or witness by warrant, he or she shall endorse on the payroll opposite the juror's or witness's name the words "Paid by warrant," giving the number and date of the warrant.

Section 6. Section 40.33, Florida Statutes, is amended to read:

40.33 Deficiency.—If the funds required for payment of the items enumerated in s. 40.29(1) in any county during a quarterly fiscal period exceeds the amount of the funds provided pursuant to s. 40.29(3), the state attorney, public defender, <u>clerk of the circuit court,</u> or criminal conflict and civil regional counsel, as applicable, shall make a further request upon the Justice Administrative Commission for the items enumerated in s.

40.29(1) for the amount necessary to allow for full payment.

Section 7. Section 40.34, Florida Statutes, is amended to read:

40.34 Clerks to make triplicate payroll.—

(1) The clerk of the court shall make out a payroll in triplicate for the payment of jurors and witnesses, which payroll shall contain:

(a) The name of each juror and witness entitled to be paid with state funds;

(b) The number of days for which the jurors and witnesses are entitled to be paid;

(c) The number of miles traveled by each; and

(d) The total compensation each juror and witness is entitled to receive.

(2) The form of such payroll shall be prescribed by the Chief Financial Officer.

(3) Compensation paid a juror or witness shall be attested as provided in s. 40.32. The payroll shall be approved by the signature of the clerk, or his or her deputy, except for the payroll as to witnesses appearing before the state attorney, which payroll shall be approved by the signature of the state attorney or an assistant state attorney.

(4) The clerks of the courts shall forward two copies of such payrolls to the Justice Administrative Commission, within 2 weeks after the last day of the quarterly fiscal period, and the commission shall audit such payrolls.

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	____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Metz offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (a) of subsection (3) of section 28.35, Florida Statutes, is amended to read:

28.35 Florida Clerks of Court Operations Corporation.—

(3)(a) The list of court-related functions that clerks may fund from filing fees, service charges, costs, and fines is limited to those functions expressly authorized by law or court rule. Those functions include the following: case maintenance; records management; court preparation and attendance; processing the assignment, reopening, and reassignment of cases; processing of appeals; collection and distribution of fines, fees, service charges, and court costs; processing of bond forfeiture payments; ~~payment of jurors and witnesses; payment of expenses~~

~~for meals or lodging provided to jurors;~~ data collection and reporting; ~~processing of jurors;~~ determinations of indigent status; and paying reasonable administrative support costs to enable the clerk of the court to carry out these court-related functions.

Section 2. Subsections (3), (4), and (5) of section 40.24, Florida Statutes, are amended to read:

40.24 Compensation and reimbursement policy.—

(3)(a) Jurors who are regularly employed and who continue to receive regular wages while serving as a juror are not entitled to receive compensation from the state ~~clerk of the circuit court~~ for the first 3 days of juror service.

(b) Jurors who are not regularly employed or who do not continue to receive regular wages while serving as a juror are entitled to receive $15 per day for the first 3 days of juror service.

(4) Each juror who serves more than 3 days is entitled to be paid by the state ~~clerk of the circuit court~~ for the fourth day of service and each day thereafter at the rate of $30 per day of service.

(5) Jurors are not entitled to additional reimbursement by the state ~~clerk of the circuit court~~ for travel or other out-of-pocket expenses.

Section 3. Section 40.29, Florida Statutes, is amended to read:

40.29 Payment of due-process costs.—

(1)(a) Each clerk of the circuit court, on behalf of the state attorney, private court-appointed counsel, the public defender, and the criminal conflict and civil regional counsel, shall forward to the Justice Administrative Commission, by county, a quarterly estimate of funds necessary to pay for ordinary witnesses, including, but not limited to, witnesses in civil traffic cases and witnesses of the state attorney, the public defender, criminal conflict and civil regional counsel, private court-appointed counsel, and persons determined to be indigent for costs. Each quarter of the state fiscal year, the commission, based upon the estimates, shall advance funds to each clerk to pay for these ordinary witnesses from state funds specifically appropriated for the payment of ordinary witnesses.

(b) Each clerk of the circuit court shall forward to the Justice Administrative Commission a quarterly estimate of funds necessary to pay compensation to jurors and for meals or lodging provided to jurors. The Clerks of Court Operations Corporation shall forward to the Justice Administrative Commission a quarterly estimate of jury related personnel costs necessary to pay each clerk of the circuit court personnel costs related to jury management.

(2) Upon receipt of an estimate pursuant to subsection (1), the Justice Administrative Commission shall endorse the amount deemed necessary for payment by the clerk of the court during the quarterly fiscal period and shall submit a request for payment to the Chief Financial Officer.

(3) Upon receipt of the funds from the Chief Financial Officer, the clerk of the court shall pay all invoices approved and submitted by the state attorney, the public defender, <u>the clerk of the court,</u> criminal conflict and civil regional counsel, and private court-appointed counsel for the items enumerated in subsection (1).

(4) After review for compliance with applicable rates and requirements, the Justice Administrative Commission shall pay all due process service related invoices, except those enumerated in subsection (1), approved and submitted by the state attorney, the public defender, <u>the clerk of the court,</u> criminal conflict and civil regional counsel, or private court-appointed counsel in accordance with the applicable requirements of ss. 29.005, 29.006, and 29.007.

Section 4. Section 40.31, Florida Statutes, is amended to read:

40.31 Justice Administrative Commission<u>; apportionment of funds; insufficient appropriations</u> ~~may apportion appropriation~~.—

<u>(1)</u> If the Justice Administrative Commission has reason to believe that the amount appropriated by the Legislature is insufficient to meet the expenses of witnesses during the remaining part of the state fiscal year, the commission may apportion the money in the treasury for that purpose among the several counties, basing such apportionment upon the amount expended for the payment of witnesses in each county during the prior fiscal year. In such case, each county shall be paid by

warrant, issued by the Chief Financial Officer, only the amount so apportioned to each county, and, when the amount so apportioned is insufficient to pay in full all the witnesses during a quarterly fiscal period, the clerk of the court shall apportion the money received pro rata among the witnesses entitled to pay and shall give to each witness a certificate of the amount of compensation still due, which certificate shall be held by the commission as other demands against the state.

(2) If the Justice Administrative Commission has reason to believe that the amount appropriated by the Legislature is insufficient to meet jury related personnel costs and expenses relating to compensation of jurors and meals and lodging provided to jurors during the remaining part of the state fiscal year, the commission may apportion the money in the treasury for those purposes among the several counties, basing such apportionment upon the amount expended for such purposes in each county during the prior fiscal year. In such case, each county shall be paid by warrant, issued by the Chief Financial Officer, only the amount so apportioned to each county. When the amount so apportioned is insufficient to pay in full all jury related personnel costs and jury-related expenses described herein during a quarterly fiscal period, the clerk of the court shall pay jurors entitled to pay before reimbursing any other jury-related expenses described herein. If the amount so apportioned is insufficient to pay in full all jurors during a quarterly fiscal period, the clerk of the court shall apportion the money

received pro rata among the jurors entitled to pay and shall give to each juror a certificate of the amount of compensation still due, which certificate shall be held by the commission as other demands against the state. If the amount so apportioned is insufficient to pay in full all jury related personnel costs during a quarterly fiscal period, the clerk of the court shall apportion the money received pro rata among the counties entitled and shall give to each county a certificate of the amount of compensation still due, which certificate shall be held by the commission as other demands against the state.

Section 5. Section 40.32, Florida Statutes, is amended to read:

40.32 Clerks to disburse money; payments to jurors and witnesses.—

(1) All moneys drawn from the treasury under ~~the provisions of~~ this chapter by the clerk of the court shall be disbursed by the clerk of the court as far as needed in payment of jurors and witnesses, except for expert witnesses paid under a contract or other professional services agreement pursuant to ss. 29.004, 29.005, 29.006, and 29.007, for the legal compensation for service during the quarterly fiscal period for which the moneys were drawn and for no other purposes.

~~(2) The payment of jurors and the payment of expenses for meals and lodging for jurors under the provisions of this chapter are court-related functions that the clerk of the court shall fund from filing fees, service charges, court costs, and~~

~~fines.~~

(2) ~~(3)~~ Jurors and witnesses shall be paid by the clerk of the court in cash, by check, or by warrant within 20 days after completion of jury service or completion of service as a witness.

(a) If the clerk of the court pays a juror or witness by cash, the juror or witness shall sign the payroll in the presence of the clerk, a deputy clerk, or some other person designated by the clerk.

(b) If the clerk pays a juror or witness by warrant, he or she shall endorse on the payroll opposite the juror's or witness's name the words "Paid by warrant," giving the number and date of the warrant.

Section 6. Section 40.33, Florida Statutes, is amended to read:

40.33 Deficiency.—If the funds required for payment of the items enumerated in s. 40.29(1) in any county during a quarterly fiscal period exceeds the amount of the funds provided pursuant to s. 40.29(3), the state attorney, public defender, clerk of the circuit court, or criminal conflict and civil regional counsel, as applicable, shall make a further request upon the Justice Administrative Commission for the items enumerated in s. 40.29(1) for the amount necessary to allow for full payment.

Section 7. Section 40.34, Florida Statutes, is amended to read:

40.34 Clerks to make triplicate payroll.—

(1) The clerk of the court shall make out a payroll in triplicate for the payment of <u>jurors and</u> witnesses, which payroll shall contain:

(a) The name of each <u>juror and</u> witness entitled to be paid with state funds;

(b) The number of days for which the <u>jurors and</u> witnesses are entitled to be paid;

(c) The number of miles traveled by each; and

(d) The total compensation each <u>juror and</u> witness is entitled to receive.

(2) The form of such payroll shall be prescribed by the Chief Financial Officer.

(3) Compensation paid a <u>juror or</u> witness shall be attested as provided in s. 40.32. The payroll shall be approved by the signature of the clerk, or his or her deputy, except for the payroll as to witnesses appearing before the state attorney, which payroll shall be approved by the signature of the state attorney or an assistant state attorney.

(4) The clerks of the courts shall forward two copies of such payrolls to the Justice Administrative Commission, within 2 weeks after the last day of the quarterly fiscal period, and the commission shall audit such payrolls.

Section 8. This act shall take effect July 1, 2016.

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

Remove everything before the enacting clause and insert: An act relating to juror costs; amending s. 28.35, F.S.; revising the list of court-related functions that clerks may fund from filing fees, service charges, costs, and fines; amending s. 40.24, F.S.; conforming provisions to changes made by the act; amending s. 40.29, F.S.; requiring the clerk and the Florida Clerks of Court Operations Corporation to forward quarterly estimates on certain jury-related costs to the Justice Administrative Commission; revising procedures governing the payment of certain costs; amending s. 40.31, F.S.; authorizing the commission to apportion funds for specified jury-related costs in certain circumstances; providing for issuance to jurors and counties of certificates for the amount of compensation still due in certain circumstances; amending s. 40.32, F.S.; conforming provisions to changes made by the act; amending s. 40.33, F.S.; authorizing the clerk to make requests to the commission for additional funds to pay certain costs in the event of a deficiency; amending s. 40.34, F.S.; requiring the clerk to provide for payroll in triplicate for the payment of jurors; requiring the clerk to forward a specified number of copies of juror payrolls to the commission by a specified date; requiring the commission to audit such payrolls; providing an effective date.