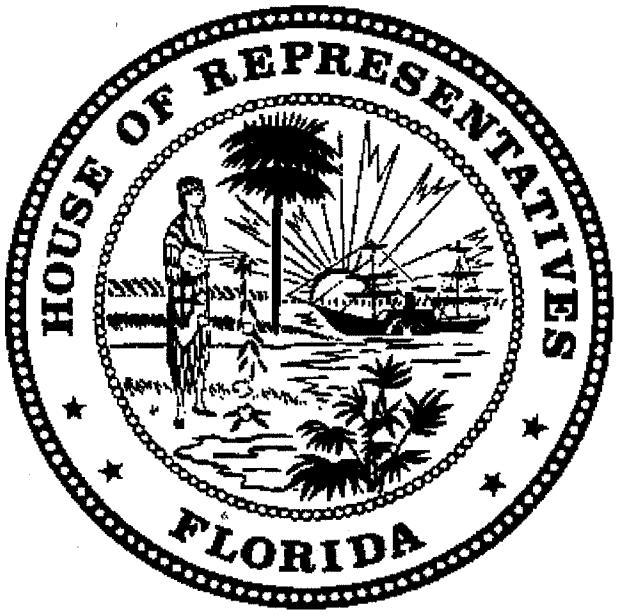

Insurance & Banking Subcommittee

Monday, January 30, 2012
2:00 PM
404 HOB

Dean Cannon
Speaker

Bryan Nelson
Chair

The Florida House of Representatives

Economic Affairs Committee

Insurance & Banking Subcommittee

Dean Cannon
Speaker

Bryan Nelson
Chair

AGENDA

January 30, 2012
404 House Office Building
2:00 p.m. - 4:30 p.m.

I. Introductory Remarks

II. HB 409 **Alien Insurers** *by Rep. Hooper*

III. HB 1065 **Annuities** *by Rep. Broxson*

IV. HB 4169 **Insurance Company Excess Profits** *by Rep. Davis*

V. HB 4181 **Workers' Compensation** *by Rep. Caldwell*

VI. PCS for HB 1277 **Money Services Businesses**

VII. Adjournment

204 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850)414-7365 Fax: (850)410-0129

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 409 Alien Insurers
SPONSOR(S): Hooper
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Cooper	Cooper
2) Economic Affairs Committee			

SUMMARY ANALYSIS

The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities authorized under the Florida Insurance Code. Regulatory oversight includes licensure, approval of rates and policy forms, market conduct and financial exams, solvency oversight, administrative supervision, and licensure of viatical settlement and premium finance companies, as provided in the Florida Insurance Code or ch. 636, F.S. The Florida Insurance Code contains provisions designed to prevent insurers from becoming insolvent and to protect policyholders. These provisions include minimum capital and surplus requirements and financial reporting requirements. Florida law requires that insurers and other risk-bearing entities obtain a certificate of authority (COA) prior to engaging in insurance transactions unless specifically exempted.

Current law provides an exemption from the requirement to obtain a COA for any insurer domiciled outside of the U.S. and covering only persons who, at the time of issuance or renewal, are nonresidents of the U.S. A "nonresident" is defined as a person who resides in and maintains a physical place of domicile in a country other than the U.S., and which (s)he intends to maintain as her or his permanent home.

The law further specifies that the insurer or any affiliated person under common ownership or control with the insurer may not solicit, sell, or accept application for any insurance policy or contract for issue or delivery to any U.S. resident. For purposes of this exemption, a U.S. resident is a person who has:

- Had her or his principal place of domicile in the United States for 180 days or more in the 365 days prior to issuance or renewal of the policy;
- Registered to vote in any state;
- Made a statement of domicile in any state; or,
- Filed for homestead tax exemption on property in any state.

To also be eligible for the exemption, the insurer must register with the OIR and provide certain relevant information to the OIR on an annual basis. The law further requires that the exempt insurer include a disclosure on all certificates issued in Florida reflecting that the policy has not been approved by the OIR.

The bill makes three primary changes to existing law. First, it deletes the reference to affiliated persons from the restriction on insurers soliciting or selling policies, or accepting applications. Thus, an insurer who has an affiliate will not be disqualified from obtaining an exemption. Second, the bill eliminates the prohibition on renewing policies to residents thereby allowing someone who was originally a nonresident at the time of issuance who subsequently becomes a resident to be insured under a non-regulated policy. Third, the bill modifies the definition of nonresident to include a trust or other entity organized and domiciled under the laws of a country other than the United States.

The bill does not have a fiscal impact on state or local government. It may have a positive, yet indeterminate, fiscal impact on the private sector.

The bill provides for an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities authorized under the Florida Insurance Code.[1] Regulatory oversight includes licensure, approval of rates and policy forms, market conduct and financial exams, solvency oversight, administrative supervision, and licensure of viatical settlement and premium finance companies, as provided in the Florida Insurance Code or ch. 636, F.S.[2] The OIR's Life and Health Financial Oversight unit monitors financial conditions through the use of internal financial analysis and on-site examinations.[3] Periodic financial report submission is part of the monitoring process. The Florida Insurance Code contains provisions designed to prevent insurers from becoming insolvent and to protect policyholders. These provisions include minimum capital and surplus requirements[4] and financial reporting requirements.[5] Florida law requires that insurers and other risk-bearing entities obtain a certificate of authority (COA) prior to engaging in insurance transactions[6, 7] unless specifically exempted.[8]

Current law provides an exemption from the requirement to obtain a COA for any insurer domiciled outside of the U.S. and covering only persons who, at the time of issuance or renewal, are nonresidents of the U.S.[9] A "nonresident" is defined as a person who resides in and maintains a physical place of domicile in a country other than the U.S., and which (s)he intends to maintain as her or his permanent home.

The bill requires that the exempt insurer include a disclosure on all certificates issued in Florida reflecting that the policy has not been approved by the OIR. The insurer or any affiliated person under common ownership or control with the insurer may not solicit, sell, or accept application for any insurance policy or contract for issue or delivery to any U.S. resident. For purposes of this subsection of statute, a U.S. resident is a person who has:

- Had her or his principal place of domicile in the United States for 180 days or more in the 365 days prior to issuance or renewal of the policy;
- Registered to vote in any state;
- Made a statement of domicile in any state; or,
- Filed for homestead tax exemption on property in any state.

Other exemption eligibility provisions require the insurer to:

- Register with the OIR.
- Provide the following information to the OIR on annual basis:
  - Names of the owners, officers and directors and number of employees.
  - Lines of insurance and types of products offered.
  - A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered in that domicile.
  - A copy of filings required by the insurer's domicile.

The bill makes three primary changes to existing law. First, it deletes the reference to affiliated persons from the restriction on insurers soliciting or selling policies, or accepting applications. Thus, an insurer who has an affiliate will not be disqualified from obtaining an exemption. Second, the bill eliminates the

[1] Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code".
[2] s. 20.121(3)(a)2., F.S.
[3] http://www.floir.com/lh/oir_LHFO_index.aspx
[4] s. 624.4095, F.S.
[5] s. 624.424, F.S.
[6] s. 624.10, F.S.
[7] s. 624.401, F.S.
[8] s. 624.402,F.S.
[9] s. 624.402(8), F.S.

prohibition on renewing policies to residents thereby allowing someone, who was originally a nonresident at the time of issuance who subsequently becomes a resident, to be insured under a non-regulated policy. Third, the bill modifies the definition of nonresident to include a trust or other entity organized and domiciled under the laws of a country other than the United States.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.402(8)(a), F.S., relating to exceptions, certificate of authority required.

Section 2: Provides an effective date of July 1, 2012.

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:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Expanding the current exemption from the COA requirement for insurers domiciled outside of the U.S. and covering only persons who, at the time of issuance or renewal, are nonresidents of the U.S. may further allow for a variety of insurance offerings. Nonresidents, in their domicile outside the U.S., may be able to purchase more health, life, property and casualty, supplemental, and other types of insurance coverage for the time they are in Florida, and for their property in the state. More nonresidents may also visit Florida to avail themselves of services covered under the policy or contract. Hence, revenue from tourism may increase.

D. FISCAL COMMENTS:

None.

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 an 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 a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

In its Bill Analysis for HB 409, OIR stated:

> At subsection (8)(a), the legislation deletes the phrase "or renewal" – thus potentially expanding the number of companies exempt from the requirement to obtain a Certificate of Authority – and could allow current residents of Florida to have policies with companies that do not have a certificate of authority if the person became a resident after the policy was issued. The Office recommends keeping the "or renewal" language in the statute.[10]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[10] OIR Bill Analysis – HB 409, November 28, 2011, on file with the Insurance & Banking Subcommittee.

A bill to be entitled

An act relating to alien insurers; amending s. 624.402, F.S.; revising a provision exempting alien insurers from being required to obtain a certificate of authority; specifying that an alien insurer is exempt from having to obtain a certificate of authority if such insurer only engages in specified activities relating to the delivery of insurance policies or contracts to nonresident policy owners; revising the definition of the term "nonresident"; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (8) of section 624.402, Florida Statutes, are amended to read:

624.402 Exceptions, certificate of authority required.—A certificate of authority shall not be required of an insurer with respect to:

(8)(a) An insurer domiciled outside the United States covering only persons who, at the time of issuance ~~or renewal~~, are nonresidents of the United States if:

1. The insurer only solicits, sells, or accepts applications for any insurance policies or contracts ~~or any affiliated person as defined in s. 624.04 under common ownership or control with the insurer does not solicit, sell, or accept application for any insurance policy or contract~~ to be delivered or issued for delivery to any nonresident policy owner ~~person in~~

~~any state~~;

2. The insurer registers with the office via a letter of notification upon commencing business from this state;

3. The insurer provides the following information, in English, to the office annually by March 1:

a. The name of the insurer; the country of domicile; the address of the insurer's principal office and office in this state; the names of the owners of the insurer and their percentage of ownership; the names of the officers and directors of the insurer; the name, e-mail, and telephone number of a contact person for the insurer; and the number of individuals who are employed by the insurer or its affiliates in this state;

b. The lines of insurance and types of products offered by the insurer;

c. A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered for those lines of insurance and types of products in that domicile; and

d. A copy of the filings required by the applicable regulatory body of the insurer's country of domicile in that country's official language or in English, if available;

4. All certificates, policies, or contracts issued in this state showing coverage under the insurer's policy include the following statement in a contrasting color and at least 10-point type: "The policy providing your coverage and the insurer providing this policy have not been approved by the Florida Office of Insurance Regulation"; and

5. In the event the insurer ceases to do business from

this state, the insurer will provide written notification to the office within 30 days after cessation.

(b) For purposes of this subsection, the term "nonresident" means either a trust or other entity organized and domiciled under the laws of a country other than the United States or a person who resides in and maintains a physical place of domicile in a country other than the United States, which he or she recognizes as and intends to maintain as his or her permanent home. A nonresident does not include an unauthorized immigrant present in the United States. Notwithstanding any other provision of law, it is conclusively presumed, for purposes of this subsection, that a person is a resident of the United States if such person has:

1. Had his or her principal place of domicile in the United States for 180 days or more in the 365 days prior to issuance or renewal of the policy;

2. Registered to vote in any state;

3. Made a statement of domicile in any state; or

4. Filed for homestead tax exemption on property in any state.

Section 2. This act shall take effect July 1, 2012.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1065 Annuities
SPONSOR(S): Broxson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1476

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Reilly	Cooper
2) Government Operations Appropriations Subcommittee			
3) Economic Affairs Committee			

SUMMARY ANALYSIS

Section 627.4554, F.S., provides protections for consumers 65 years of age and older in annuity transactions. The section, enacted in 2004, adopted the National Association of Insurance Commissioners' (NAIC) Senior Protection in Annuity Transactions Model Regulation of 2003. In 2008, the Legislature amended the law to provide additional safeguards for senior consumers that are not in the NAIC's model regulation. These include requiring insurers and agents to document on forms promulgated by the Department of Financial Services (DFS): (1) information obtained from consumers relating to the suitability of a particular product for the consumer and (2) explaining the differences between the policies recommended by the agent or insurer and existing policies, for transactions involving the exchange of policies. In both circumstances, insurers and agents are required to provide the consumer with a signed copy of the completed DFS form. The legislation also authorizes the Office of Insurance Regulation to take reasonably appropriate corrective actions against insurers for violation of s. 627.4554, F.S., including rescission of the policy or contract and a full refund of the premiums paid or the accumulation value, whichever is greater. In 2010, the Legislature also increased the unconditional refund period for senior consumers to 21 days and required insurers to attach a cover page, with specified information, to any annuity policy sold.

The bill amends s. 627.4554, F.S., to incorporate into Florida law the most current version of the NAIC model regulation on annuity protections (the 2010 NAIC Model). The 2010 NAIC Model, which has been enacted by 19 states, including California and New York, provides annuity protections for consumers of any age; insurer review of every annuity transaction; and an annuity training program for agents. It also clarifies that insurers are responsible for compliance with annuity protection provisions, even when they contract with third parties. The 2010 NAIC Model, however, does not reflect the 2008 changes to s. 627.4554, F.S. The bill also decreases the unconditional refund period for senior consumers from 21 to 14 days and eliminates the requirement that insurers attach a cover page to each annuity policy sold.

The DFS informs that the additional continuing education courses it would need to approve and administratively support would require an additional FTE in the Division of Agent & Agency Services. Costs would also be incurred in modifying DFS's education database. OIR reports that the bill will result in an increase in form re-filings, and thus an increased workload.

The bill is effective July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Annuities[1]

An annuity is a contract between a buyer and an insurance company that provides guaranteed payments over a period of time. Annuities are designed to meet retirement and long-range planning goals,[2] and are long-term contracts that typically restrict an investor's ability to access their money.

There are two basic types of annuities, fixed and variable. Fixed annuities guarantee both the rate of return and the amount of payout. Variable annuities do not guarantee the rate of return, which can fluctuate based on the performance of underlying investment options chosen by the purchaser.

Fixed and variable annuities are available as either immediate or deferred annuities. Typically, premiums for immediate annuities are paid in a lump sum amount, and the purchaser receives an immediate and regular stream of payments for a period of time. Variable annuities generally involve an accumulation phase, during which premiums paid experience tax-deferred growth, and the payout phase (annuitization phase) when the annuity provides a regular stream of periodic payments to the purchaser.

Fixed annuities are considered insurance contracts because of the mortality risk associated with payout options, and are regulated by state insurance departments. With a variable annuity, premium dollars are placed into a variety of investment options called subaccounts. Because variable annuities involve risk and provide no guarantee of principal, they are considered investments and fall within the jurisdiction of both securities regulators and state insurance departments. Agents selling variable annuities must hold a variable annuity license from the state and also possess a securities license and hold an active securities registration with a broker dealer. As investments, variable annuities also have accompanying prospectuses with disclosures regarding risk. All sales of variable annuities are subject to suitability standards established by the Financial Industry Regulatory Authority (FINRA).[3]

Equity indexed annuities are considered a hybrid of both fixed and variable annuities. They are classified, defined, and regulated as fixed annuities. In contrast to a traditional fixed annuity, which provides a stated guaranteed rate of interest, equity indexed annuities provide a minimum guaranteed interest rate in combination with an index-linked component. A guaranteed minimum interest rate may still create a loss of principal if the guarantee is based on an amount less than the amount of premium or initial payment. Investors who find it necessary to cancel an annuity to access funds prior to maturity of the contract may also lose principal through detrimental features such as surrender charges, hidden penalties, costs, fees, and massive multi-year surrender charges.

Determining whether an Annuity is a Suitable Investment for a Consumer: Suitability Issues

In 2003, the National Association of Insurance Commissioners (NAIC) adopted the "Senior Protection in Annuity Transactions Model Regulation" (Model Regulation), designed to help protect senior citizens when they purchase or exchange annuity products. In 2004, Florida adopted the Model Regulation by

[1] Background information on annuities derived from "2008 White Paper on Annuities," by Roxanne Rehm, 2008 Assistant General Counsel for the DFS. On file with staff of the Insurance & Banking Subcommittee.

[2] See "Annuities," U.S. Securities and Exchange Commission at hhtp://www.sec.gov/answers/annuity.htm (Last accessed January 27, 2012).

[3] The Financial Industry Regulatory Authority (FINRA) is the largest independent regulator for all securities firms doing business in the United States.

creating s. 627.4554, F.S. This section provides protection for senior citizens in annuity transactions, requiring insurance companies and agents offering these products to clearly document the basis for selling the product, including consideration of a senior citizen's financial and tax status, as well as investment objectives. In 2006, the NAIC removed the age restriction from its Model Regulation, extending annuity protections to consumers of any age.

In 2008, Florida amended s. 627.4554, F.S. Although the legislation did not incorporate the 2006 change to the Model Regulation, it provided additional safeguards for senior consumers, including:

- Requiring insurers and agents to have an "objectively" reasonable basis for recommending a particular annuity product.
- Specifying the minimum information that an insurer or agent must obtain and use to determine the suitability of a recommendation before executing a purchase or exchange of a policy.
- Requiring suitability information obtained from a consumer to be recorded on a Department of Financial Services' (DFS) form, which must be completed and signed by the applicant and the agent, with a copy given to the consumer.
- Requiring the insurer or agent, in exchange situations, to provide the consumer with specified information, on a DFS form, concerning differences between the policy being recommended for purchase and an existing policy that would be surrendered or replaced.
- Increasing the "free look" refund period.
- Authorizing the Office of Insurance Regulation to rescind an annuity and provide a full refund of premiums paid or the accumulation value, whichever is greater, when a consumer is harmed by a violation of the suitability statute.

In 2010, the Legislature also increased the unconditional refund period for senior consumers in annuity transactions to 21 days and required insurers to attach a cover page with specified information, including notice of the refund period, contact information, and the name of the issuing company and selling agent, to each annuity sold.[4]

In March 2010, the NAIC revised its Model Regulation to clarify that insurers are responsible for compliance with the model's requirements, even if the insurer contracts with a third party; requiring insurers to review all annuity transactions; and establishing both general and product-specific training requirements for insurance agents.

To date, 19 states, including New York and California, have adopted the 2010 version of the NAIC's Model Regulation.

Effect of the Bill

The bill amends s. 627.4554, F.S., to incorporate into Florida law the most recent version of the NAIC's Model Regulation on protections in annuity transactions. The bill makes the following changes to existing law:

- Extends the protections currently afforded to senior citizens to consumers of any age and sophistication level.
- Revises definitions; defines additional terms relevant to annuity transactions, including Annuity, FINRA (Financial Regulatory Authority), Recommendation, Replacement, and Suitability Information.
- Requires insurers or agents to have reasonable grounds (as opposed to "objectively" reasonable grounds under current law) for believing that recommendations made to a consumer to purchase, exchange, or replace annuity products are suitable to the consumer's circumstances and that there are reasonable grounds to believe that:
    - The consumer has been reasonably informed of specified information.
    - The consumer would benefit from the product recommended.
    - That the annuity as a whole (or the exchange or replacement of a policy) is suitable for the consumer.

[4] Section 626.99, F.S.

- Prohibits agents from dissuading, or attempting to dissuade a consumer from truthfully responding to an insurer's request for confirmation of suitability information, or from cooperating with the investigation of a complaint.
- Clarifies that compliance with FINRA requirements constitutes compliance with s. 627.4554, F.S.
- Establishes training requirements for agents, including completion of a one-time annuity training course approved by the DFS, which must qualify for at least 4 hours of continuing education credit; and requiring agents to have sufficient knowledge of an annuity product and to be in compliance with the insurer's standard for product training, prior to soliciting the sale of a product .
- Requires insurers to verify that agents have completed the training.
- Provides that insurers are responsible for ensuring compliance with the law.
- Requires insurers to establish a supervision system that is reasonably designed to achieve insurer and agent compliance with this section, which must include procedures for the review of each recommendation before issuance of an annuity; specified training materials; and annual reports to senior managers to determine the effectiveness of the supervision system. Permits insurers to contract with a third party as to any aspect of the supervision system, but provides that insurers remain responsible for compliance.
- Requires insurers or agents to make reasonable efforts to obtain suitability information from consumers and to document recommendations that result in annuity transactions; eliminates the requirement that the information be recorded on a DFS form, with a copy of the completed form being given to the consumer.
- When an annuity product is to be exchanged or replaced, removes the requirement that the consumer be given specified information, on a DFS form, explaining the differences between the products being recommended for purchase and the policies that are being surrendered or replaced.

The bill also amends s. 626.99, F.S., to decrease the unconditional refund period from 21 to 14 days for senior consumers and removes the requirement that insurers attach a cover page with specified information to every annuity policy sold.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.4554, F.S., to incorporate the 2010 amendments to NAIC's model regulation on protections in annuity transactions into Florida law.

Section 2. Amends s. 626.99, F.S., to provide a 14 day unconditional refund period for senior consumers who purchase annuities and to eliminate the requirement that a cover page with specified information be attached to all annuity policies sold.

Section 3. Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DFS informs that the additional continuing education courses it would need to approve and administratively support would require an additional FTE (Insurance Analyst II) in the Division of Agent & Agency Services. Costs would also be incurred in modifying DFS's education database. OIR reports that the bill will result in an increase in form re-filings, and thus an increased workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the bill provides for enactment of the most recent version of the NAIC model regulation on annuity protections, adopted by the NAIC in 2010 and enacted in 19 states to date, it will bring further uniformity to the sale of annuity products by insurers conducting business in multiple states.

The requirement for agents who sell annuities to take additional continuing education courses approved by the DFS increases the regulatory burden on insurers and agents.

D. FISCAL COMMENTS:

The DFS informs that the additional continuing education courses it would need to approve and administratively support would require an additional FTE in the Division of Agent & Agency Services. Costs would also be incurred in modifying DFS's education database. OIR reports that the bill will result in an increase in form re-filings, and thus an increased workload.

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 an 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 a state tax shared with counties or municipalities.

2. Other:

To the extent that the bill extends the protections of s. 627.4554, F.S., to all purchasers of annuities, it will protect a greater number of consumers in annuity transactions. However, the bill eliminates some standardized DFS forms that are currently used by insurers and agents to document suitability information obtained from senior consumers; to provide comparative information when an annuity transaction involves the exchange or surrender of a current policy; and the requirement that each annuity policy sold to a senior contain a cover page with specified information.

B. RULE-MAKING AUTHORITY:

Authorizes the DFS to adopt rules to administer s. 627.4554, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Staff has been informed that amendments will be filed that make technical changes, increase the unconditional refund period from 14 to 21 days for all consumers, delete the additional training requirements, and change the effective date of the bill to allow sufficient time for insurers to file forms for approval with the Office of Insurance Regulation.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to annuities; amending s. 627.4554, F.S.; providing that recommendations relating to annuities made by an insurer or its agents apply to all consumers not just to senior consumers; revising and providing definitions; revising the duties of insurers and agents; providing that recommendations must be based on consumer suitability information; deleting requirements relating to information that must be collected on certain forms adopted by rule of the Department of Financial Services; revising the information relating to annuities that must be provided by the insurer or its agent to the consumer; revising the requirements for monitoring contractors that are providing certain functions for the insurer relating to the insurer's system for supervising recommendations; revising provisions relating to the relationship between this act and the federal Financial Industry Regulatory Authority; providing training requirements for agents selling annuities; deleting a provision providing a cap on surrender or deferred sales charges; amending s. 626.99, F.S.; deleting certain annuity policy requirements applicable to persons 65 years of age or older; providing an effective date.

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

Section 1. Section 627.4554, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 627.4554, F.S., for present text.)

627.4554 Annuity investments.—

(1) PURPOSE.—The purpose of this section is to require insurers to set forth standards and procedures for making recommendations to consumers which result in transactions involving annuity products, and to establish a system for supervising such recommendations in order to ensure that the insurance needs and financial objectives of consumers are appropriately addressed at the time of the transaction.

(2) SCOPE.—This section applies to any recommendation made to a consumer to purchase, exchange, or replace an annuity by an insurer or its agent, and which results in the purchase, exchange, or replacement recommended.

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

(a) "Agent" has the same meaning as provided in s. 626.015.

(b) "Annuity" means an insurance product under state law which is individually solicited, whether classified as an individual or group annuity.

(c) "FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

(d) "Insurer" has the same meaning as provided in s. 624.03.

(e) "Recommendation" means advice provided by an insurer or its agent to a consumer which results in the purchase,

exchange or replacement of an annuity in accordance with that advice.

(f) "Replacement" means a transaction in which a new policy or contract is to be purchased and it is known or should be known to the proposing insurer or its agent that by reason of such transaction an existing policy or contract will be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;

2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value due to the use of nonforfeiture benefits or other policy values;

3. Amended so as to effect a reduction in benefits or the term for which coverage would otherwise remain in force or for which benefits would be paid;

4. Reissued with a reduction in cash value; or

5. Used in a financed purchase.

(g) "Suitability information" means information related to the consumer that is reasonably appropriate to determine the suitability of a recommendation made to the consumer, including the following:

1. Age;

2. Annual income;

3. Financial situation and needs, including the financial resources used for funding the annuity;

4. Financial experience;

5. Financial objectives;

6. Intended use of the annuity;

7. Financial time horizon;

8. Existing assets, including investment and life insurance holdings;

9. Liquidity needs;

10. Liquid net worth;

11. Risk tolerance; and

12. Tax status.

(4) EXEMPTIONS.—This section does not apply to transactions involving:

(a) Direct-response solicitations if the recommendation is not based on suitability information collected from the consumer pursuant to this section;

(b) Contracts used to fund:

1. An employee pension or welfare benefit plan that is covered by the federal Employee Retirement and Income Security Act;

2. A plan described by s. 401(a), s. 401(k), s. 403(b), s. 408(k), or s. 408(p) of the Internal Revenue Code, if established or maintained by an employer;

3. A government or church plan defined in s. 414 of the Internal Revenue Code, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under s. 457 of the Internal Revenue Code;

4. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

5. Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim-

resolution process; or

6. Formal prepaid funeral contracts.

(5) DUTIES OF INSURERS AND AGENTS.—

(a) When recommending the purchase or exchange of an annuity to a consumer which results in an insurance transaction or series of insurance transactions, the insurer or its agent must have reasonable grounds for believing that the recommendation is suitable for the consumer, based on the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

1. The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity; mortality and expense fees; investment advisory fees; potential charges for and features of riders; limitations on interest returns; insurance and investment components; and market risk.

2. The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, or the death or living benefit.

3. The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable; and, in the case of an exchange or replacement, the transaction as a whole is suitable for the particular consumer based on his or her suitability information.

4. In the case of an exchange or replacement of an

annuity, the exchange or replacement is suitable after taking into consideration whether the consumer:

a. Will incur a surrender charge; be subject to the commencement of a new surrender period; lose existing benefits, such as death, living, or other contractual benefits; or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

b. Would benefit from product enhancements and improvements; and

c. Has had another annuity exchange or replacement, in particular, an exchange or replacement within the preceding 36 months.

(b) Before executing a purchase, exchange, or replacement of an annuity resulting from a recommendation, an insurer or its agent must make reasonable efforts to obtain the consumer's suitability information.

(c) Except as provided under paragraph (d), an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

(d) An insurer's issuance of an annuity must be reasonable based on all the circumstances actually known to the insurer at the time the annuity is issued. However, an insurer or its agent does not have an obligation to a consumer related to an annuity transaction under paragraph (a) or paragraph (c) if:

1. A recommendation has not been made;

2. A recommendation was made and is later found to have been based on materially inaccurate information provided by the

consumer;

3. A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or

4. A consumer decides to enter into an annuity transaction that is not based on a recommendation of an insurer or its agent.

(e) At the time of sale, the agent or the agent's representative must:

1. Make a record of any recommendation made to the consumer pursuant to paragraph (a);

2. Obtain the consumer's signed statement documenting his or her refusal to provide suitability information, if applicable; and

3. Obtain the consumer's signed statement acknowledging that an annuity transaction is not recommended if he or she decides to enter into an annuity transaction that is not based on the insurer's or its agent's recommendation, if applicable.

(f) An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its agent's compliance with this section.

1. Such system must include, but is not limited to:

a. Maintaining reasonable procedures to inform its agents of the requirements of this section and incorporating those requirements into relevant agent training manuals;

b. Establishing standards for agent product training and maintaining reasonable procedures that require its agents to comply with subsection (7);

c. Providing product-specific training and training

materials that explain all material features of its annuity products to its agents;

d. Maintaining procedures for the review of each recommendation before issuance of an annuity which are designed to ensure that there is a reasonable basis for determining that a recommendation is suitable. Such review procedures may use a screening system for identifying selected transactions for additional review and may be accomplished electronically or through other means, including, but not limited to, physical review. Such electronic or other system may be designed to require additional review only of those transactions identified for additional review using established selection criteria;

e. Maintaining reasonable procedures to detect recommendations that are not suitable. These may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, consumer interviews, confirmation letters, and internal monitoring programs. This sub-subparagraph does not prevent an insurer from using sampling procedures or from confirming suitability information after the issuance or delivery of the annuity; and

f. Annually providing a report to senior managers, including the senior manager who is responsible for audit functions, which details a review, along with appropriate testing, which is reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

2. An insurer is not required to include in its supervision system agent recommendations to consumers of

products other than the annuities offered by the insurer.

3. An insurer may contract for performance of a function required under subparagraph 1.

a. If an insurer contracts for the performance of a function, the insurer must include the supervision of contractual performance as part of those procedures listed in subparagraph 1. These include, but are not limited to:

(I) Monitoring and, as appropriate, conducting audits to ensure that the contracted function is properly performed; and

(II) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis for representing that the function is being properly performed.

b. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to subsection (8) regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with sub-subparagraph a.

(g) An agent may not dissuade, or attempt to dissuade, a consumer from:

1. Truthfully responding to an insurer's request for confirmation of suitability information;

2. Filing a complaint; or

3. Cooperating with the investigation of a complaint.

(h) Sales made in compliance with FINRA requirements pertaining to the suitability and supervision of annuity transactions must satisfy the requirements of this section. This paragraph applies to FINRA broker-dealer sales of variable

annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, this paragraph does not limit the ability of the office or the department to enforce, including investigate, the provisions of this section. For this paragraph to apply, an insurer must:

1. Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

2. Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer in maintaining its supervision system.

(6) RECORDKEEPING.—

(a) Insurers and agents must maintain or be able to make available to the office or department records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for 5 years after the insurance transaction is completed by the insurer. An insurer may maintain the documentation on behalf of its agent.

(b) Records required to be maintained under this subsection may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces the actual document.

(7) AGENT TRAINING.—

(a) An agent may not solicit the sale of an annuity product unless the agent has sufficient knowledge of the product to recommend the annuity and the agent is in compliance with the insurer's standards for product training. An agent may rely on

insurer-provided, product-specific training standards and materials in order to comply with this paragraph.

(b) An agent who engages in the sale of annuity products must complete a one-time annuity training course approved by the department.

1. The minimum length of the training course must be sufficient to qualify for at least 4 hours of continuing education under s. 626.2815, but may be longer.

2. The training must include information on the following topics:

a. The types of annuities and various classifications of annuities.

b. Identification of the parties to an annuity.

c. How fixed, variable, and indexed annuity contract provisions affect consumers.

d. Income taxation of qualified and nonqualified annuities.

e. The primary uses of annuities.

f. Appropriate sales practices, replacement, and disclosure requirements.

3. The training course may be conducted and completed by classroom or a self-study program in accordance with s. 626.2815.

(c) A provider of an annuity training course must comply with s. 626.2816 and the rules applicable to continuing education courses adopted under that section.

1. Providers must cover all topics listed in subparagraph (b)2. and may not present any marketing information or provide

training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with the required topics.

2. Providers must comply with the reporting requirements and issue certificates of completion in accordance with s. 626.2815.

(d) An insurer shall verify that its agent has completed the annuity training course required under this subsection before allowing the agent to sell an annuity product for that insurer. An insurer may satisfy this requirement by obtaining certificates of completion of the training course or obtaining reports provided by office-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

(e) Agents that hold a life insurance line of authority on July 1, 2012, and that desire to sell annuities must complete the annuity training course within 6 months after that date. Individuals who obtain a life insurance line of authority on or after July 1, 2012, may not engage in the sale of annuities until the annuity training course has been completed.

(f) Satisfaction of the training requirements of another state which are substantially similar to this subsection satisfy the training requirements of this subsection.

(8) COMPLIANCE MITIGATION; PENALTIES.—

(a) An insurer is responsible for compliance with this section. If a violation occurs because of the action or inaction of the insurer or its agent, the office may order an insurer to

take reasonably appropriate corrective action for a consumer harmed by the insurer's or by its agent's violation of this section and may impose appropriate penalties and sanctions.

(b) The department may order:

1. An insurance agent to take reasonably appropriate corrective action, including monetary restitution of penalties or fees incurred by the consumer for any consumer harmed by a violation of this section by the insurance agent and impose appropriate penalties and sanctions.

2. A managing general agency or insurance agency that employs or contracts with an insurance agent to sell or solicit the sale of annuities to consumers must take reasonably appropriate corrective action for a consumer harmed by a violation of this section by the insurance agent.

(c) In addition to any other penalty authorized under chapter 626, the department shall order an insurance agent to pay restitution to a consumer who has been deprived of money by the agent's misappropriation, conversion, or unlawful withholding of moneys belonging to the senior consumer in the course of a transaction involving annuities. The amount of restitution required to be paid may not exceed the amount misappropriated, converted, or unlawfully withheld. This paragraph does not limit or restrict a person's right to seek other remedies as provided by law.

(d) Any applicable penalty under the Florida Insurance Code for a violation of this section shall be reduced or eliminated according to a schedule adopted by the office or the department, as appropriate, if corrective action for the

consumer was taken promptly after a violation was discovered.

(e) A violation of this section does not create or imply a private cause of action.

(9) RULES.—The department may adopt rules to administer this section.

Section 2. Subsection (4) of section 626.99, Florida Statutes, is amended to read:

626.99 Life insurance solicitation.—

(4) DISCLOSURE REQUIREMENTS.—

(a) The insurer shall provide to each prospective purchaser a buyer's guide and a policy summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made provides an unconditional refund for ~~a period of~~ at least 14 days, or unless the policy summary contains an offer of such an unconditional refund. In these instances, the buyer's guide and policy summary must be delivered with the policy or before ~~prior to~~ delivery of the policy.

(b) With respect to fixed and variable annuities, the policy must provide an unconditional refund for ~~a period of~~ at least 14 days. For fixed annuities, the buyer's guide must ~~shall~~ be in the form ~~as~~ provided by the National Association of Insurance Commissioners (NAIC) Annuity Disclosure Model Regulation, until ~~such time as~~ a buyer's guide is developed by the department, at which time the department guide must be used. For variable annuities, a policy summary may be used, which may be contained in a prospectus, until such time as a buyer's guide is developed by NAIC or the department, at which time one of

those guides must be used. ~~If the prospective owner of an annuity contract is 65 years of age or older:~~

~~1. An unconditional refund of premiums paid for a fixed annuity contract, including any contract fees or charges, must be available for a period of 21 days; and~~

~~2. An unconditional refund for variable or market value annuity contracts must be available for a period of 21 days. The unconditional refund shall be equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract. This subparagraph does not apply if the prospective owner is an accredited investor, as defined in Regulation D as adopted by the United States Securities and Exchange Commission.~~

~~(c) The insurer shall attach a cover page to any annuity policy informing the purchaser of the unconditional refund period prescribed in paragraph (b). The cover page must also provide contact information for the issuing company and the selling agent, the department's toll-free help line, and any other information required by the department by rule. The cover page is part of the policy and is subject to review by the office pursuant to s. 627.410.~~

(c) ~~(d)~~ The insurer shall provide a buyer's guide and a policy summary to a ~~any~~ prospective purchaser upon request.

Section 3. This act shall take effect July 1, 2012.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 4169 Insurance Company Excess Profits
SPONSOR(S): Davis
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Reilly	Cooper
2) Economic Affairs Committee			

SUMMARY ANALYSIS

In Florida, workers' compensation insurers do not file their own rates. Rather, rate filings are made by the National Council on Compensation Insurance, the designated licensed rating and statistical organization for Florida's workers' compensation insurers. Workers' compensation rate filings are submitted to the Office of Insurance Regulation (OIR) and ultimately either approved or disapproved after a public hearing.

Pursuant to s. 627.215, F.S., workers' compensation insurers (and insurers in specified other lines) are required to return excess profits to the businesses they insure. The law requires companies to report the following data to the OIR: calendar year earned premium; accident year incurred losses and loss adjustment expenses; administrative and selling expenses incurred in Florida or allocated to the state for the calendar year; and policyholder dividends applicable to the calendar year. An excess profit is realized if an insurer's underwriting gains are greater than the anticipated underwriting profit, plus five percent, for the three most recent calendar years. Insurers that realize excess profits are required to issue refunds to policyholders in the form of cash or a credit. The OIR reports that workers' compensation insurers have returned over $200 million in excess profits to their policyholders since 2003.

The bill excludes workers' compensation insurers from excess profit provisions. The excess profit law for workers' compensation was enacted in 1979 to coincide with the implementation of a wage-loss benefit reform (no longer utilized) to protect employers by ensuring that excess profits generated by the expected reduction in benefits for injured workers were returned to employers.

Supporters of the excess profit law believe that it is important because it protects against potential shortcomings in the promulgated rate system that may lead to a windfall for certain employers. Opponents believe that since rates are set by the state, and not by the insurance company, the law penalizes insurers for efficiencies that allow them to realize higher profits than competitors. Opponents also believe that elimination of the excess profit law would encourage more insurers to write workers' compensation insurance in Florida.

The bill has no fiscal impact on state and local government. Workers' compensation insurers will be able to retain any profits realized, and insured businesses will no longer receive refunds based on an insurer's excess profits.

The law is effective July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Workers' Compensation Premiums in Florida

In Florida, workers' compensation insurers do not file their own rates. Rather, rate filings are made by the National Council on Compensation Insurance, the designated licensed rating and statistical organization for Florida's workers' compensation insurers. Workers' compensation rate filings are submitted to the Office of Insurance Regulation (OIR) and ultimately either approved or disapproved after a public hearing.

Excess Profits Law

Pursuant to s. 627.215, F.S., workers' compensation insurers (and insurers in specified other lines) are required to return "excess profits" to the businesses they insure. The law requires companies to report the following data to the OIR: calendar year earned premium; accident year incurred losses and loss adjustment expenses; administrative and selling expenses incurred in Florida or allocated to the state for the calendar year; and policyholder dividends applicable to the calendar year. An excess profit is realized if an insurer's underwriting gains are greater than the anticipated underwriting profit, plus five percent, for the three most recent calendar years. Insurers that realize excess profits are required to issue refunds to policyholders in the form of cash or a credit. The OIR reports that workers' compensation insurers have returned over $200 million in excess profits to their policyholders since 2003.[1]

The excess profit law for workers' compensation was enacted in 1979 to coincide with the implementation of a wage-loss benefit reform (no longer utilized) to protect employers by ensuring that excess profits generated by the expected reduction in benefits for injured workers' were returned to employers.

Effect of the Bill

The bill excludes workers' compensation insurers from excess profit provisions.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.215, F.S., to exclude workers' compensation from excess profit provisions.

Section 2. Amends s. 628.6017, F.S., to provide a conforming change.

Section 3. Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

[1] OIR analysis of HB 4169, dated January 5, 2012. On file with staff of the Insurance & Banking Subcommittee.

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurers that most effectively manage their risks will be able to retain additional profits realized from their efforts. Additional workers' compensation insurers will likely consider writing business in the state as the limitation on excess profits is removed.

Businesses will no longer be entitled to refunds that resulted from an insurer's excess profits.

D. FISCAL COMMENTS:

Insurers will be able to retain higher profits that otherwise would have been returned to employers.

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 an 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 a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

To eliminate uncertainty and avoid litigation, it may be useful to include language that excess profits for workers' compensation and employers liability is eliminated for any years that are required to be filed on July 1, 2012 and subsequently, but that excess profits for prior years are not affected by the bill.

Supporters of the excess profit law believe that it is important because it protects against potential shortcomings in the promulgated rate system that may lead to a windfall for certain employers. Opponents believe that since rates are set by the state, and not by the insurance company, the law penalizes insurers for efficiencies that allow them to realize higher profits than competitors. Opponents also believe that elimination of the excess profit law would encourage more insurers to write workers' compensation insurance in Florida.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to insurance company excess profits; amending s. 627.215, F.S., which prohibits insurance companies from realizing excessive profits for writing certain lines of insurance coverage, to delete workers' compensation and employer's liability insurance coverages from the list of lines for which excessive profits are prohibited; amending s. 628.6017, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Section 627.215, Florida Statutes, is amended to read:

627.215 Excessive profits for ~~workers' compensation, employer's liability,~~ commercial property~~,~~ and commercial casualty insurance prohibited.—

(1)(a) Each insurer group writing ~~workers' compensation and employer's liability insurance as defined in s. 624.605(1)(c),~~ commercial property insurance as defined in s. 627.0625, commercial umbrella liability insurance as defined in s. 627.0625, or commercial casualty insurance as defined in s. 627.0625 shall file with the office prior to July 1 of each year, on a form prescribed by the commission, the following data for the component types of such insurance as provided in the form:

1. Calendar-year earned premium.

2. Accident-year incurred losses and loss adjustment expenses.

3. The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.

4. Policyholder dividends applicable to the calendar year.

Nothing herein is intended to prohibit an insurer from filing on a calendar-year basis.

(b) The data filed for the group shall be a consolidation of the data of the individual insurers of the group. However, an insurer may elect to either consolidate commercial umbrella liability insurance data with commercial casualty insurance data or to separately file data for commercial umbrella liability insurance. Each insurer shall elect its method of filing commercial umbrella liability insurance at the time of filing data for accident year 1987 and shall thereafter continue filing under the same method. In the case of commercial umbrella liability insurance data reported separately, a separate excessive profits test shall be applied and the test period shall be 10 years. ~~In the case of workers' compensation and employer's liability insurance, the final report for the test period including accident years 1984, 1985, and 1986 must be filed prior to July 1, 1988.~~ In the case of commercial property and commercial casualty insurance, the final report for the test period including accident years 1987, 1988, and 1989 must be filed prior to July 1, 1991.

~~(2) Each insurer group writing workers' compensation and employer's liability insurance shall also file a schedule of~~

~~Florida loss and loss adjustment experience for each of the 3 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year to be reported, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of three evaluations will be provided for each accident year. The first year to be so reported shall be accident year 1984, so that the reporting of 3 accident years under this revised evaluation will not take place until accident years 1985 and 1986 have become available. For reporting purposes unrelated to determining excessive profits, the loss and loss adjustment experience of each accident year shall continue to be reported until each accident year has been reported at eight stages of development.~~

(2) ~~(3)~~ (a) Each insurer group writing commercial property insurance or commercial casualty insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 3 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 3 evaluations will be provided for each accident year. The first year to be so reported shall be accident year 1987, which shall first be reported on or before July 1, 1989, and the reporting of 3 accident years will not take place until accident years 1988 and 1989 have become available. For medical

malpractice insurance, the first year to be so reported shall be accident year 1990, which shall first be reported on or before July 1, 1992, and the reporting of 3 accident years for full inclusion of medical malpractice experience in commercial casualty insurance will not take place until accident years 1991 and 1992 become available. Accordingly, no medical malpractice insured shall be eligible for refunds or credits until the reporting period ending with calendar-accident year 1992. For reporting purposes unrelated to determining excess profits, the loss and loss adjustment experience of each accident year shall continue to be reported until each accident year has been reported at eight stages of development.

(b) Each insurer group writing commercial umbrella liability insurance which elects to file separate data for such insurance shall also file a schedule of Florida loss and loss adjustment experience for each of the 10 years previous to the most recent accident year. The incurred losses and loss adjustment expenses shall be valued as of December 31 of the first year following the latest accident year, developed to an ultimate basis, and at nine 12-month intervals thereafter, each developed to an ultimate basis, so that a total of 10 evaluations will be provided for each accident year. The first year to be so reported shall be accident year 1987, which shall first be reported on or before October 1, 1989, and the reporting of 10 accident years will not take place until accident year 1996 data is reported.

(3) ~~(4)~~ Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: The

sum of the accident-year incurred losses and loss adjustment expenses as of December 31 of the year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, shall be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.

(4) ~~(5)~~ For the 3 most recent calendar-accident years for which data is to be filed under this section, the underwriting gain or loss shall be compared to the anticipated underwriting profit, except in the case of separately reported commercial umbrella liability insurance for which such comparison shall be made for the 10 most recent calendar-accident years.

~~(6) For those insurer groups writing workers' compensation and employer's liability insurance during the years 1984, 1985, 1986, 1987, and 1988, an excessive profit has been realized if underwriting gain is greater than the anticipated underwriting profit plus 5 percent of earned premiums for the 3 most recent calendar years for which data is to be filed under this section. Any excess profit of an insurance company offering workers' compensation or employer's liability insurance during this period of time, shall be returned to policyholders in the form of a cash refund or a credit toward future purchase of insurance. The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the workers' compensation policyholders of record of the insurer group on December 31 of the final compilation year.~~

(5) ~~(7)~~ (a) Beginning with the July 1, 1991, report for ~~workers' compensation insurance, employer's liability insurance,~~

commercial property insurance~~,~~ and commercial casualty insurance, an excessive profit has been realized if the net aggregate underwriting gain for ~~all~~ these lines combined is greater than the net aggregate anticipated underwriting profit for these lines plus 5 percent of earned premiums for the 3 most recent calendar years for which data is to be filed under this section. For calculation purposes commercial property insurance and commercial casualty insurance shall be broken down into sublines in order to ascertain the anticipated underwriting profit factor versus the actual underwriting gain for the given subline.

(b) Beginning with the July 1, 1998, report for commercial umbrella liability insurance, if an insurer has elected to file data separately for such insurance, an excessive profit has been realized if the underwriting gain for such insurance is greater than the anticipated underwriting profit for such insurance plus 5 percent of earned premiums for the 10 most recent calendar years for which data is to be filed under this section.

(6)~~(8)~~ As used in this section with respect to any 3-year period, or with respect to any 10-year period in the case of commercial umbrella liability insurance, "anticipated underwriting profit" means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated

by Florida business, except that the anticipated underwriting profit for the purposes of this section shall be calculated using a profit and contingencies factor that is not less than zero. Separate calculations need not be made for consecutive rate filings containing the same percentage factor for profits and contingencies.

(7) ~~(9)~~ If the insurer group has realized an excessive profit, the office shall order a return of the excessive amounts after affording the insurer group an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be refunded in all instances unless the insurer group affirmatively demonstrates to the office that the refund of the excessive amounts will render a member of the insurer group financially impaired or will render it insolvent under the provisions of the Florida Insurance Code.

(8) ~~(10)~~ Any excess profit of an insurance company as determined on July 1, 1991, and thereafter shall be returned to policyholders in the form of a cash refund or a credit toward the future purchase of insurance. The excessive amount shall be refunded on a pro rata basis in relation to the final compilation year earned premiums to the policyholders of record of the insurer group on December 31 of the final compilation year.

(9) ~~(11)~~ (a) Cash refunds to policyholders may be rounded to the nearest dollar.

(b) Data in required reports to the office may be rounded to the nearest dollar.

(c) Rounding, if elected by the insurer, shall be applied

consistently.

(10)~~(12)~~(a) Refunds shall be completed in one of the following ways:

1. If the insurer group elects to make a cash refund, the refund shall be completed within 60 days of entry of a final order indicating that excessive profits have been realized.

2. If the insurer group elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order indicating that excessive profits have been realized. If an insurer group has made this election but an insured thereafter cancels her or his policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer group shall immediately certify to the office that the refunds have been made.

(11)~~(13)~~ Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year immediately succeeding the compilation period giving rise to the refund or credit, for purposes of reporting under this section for subsequent years.

(12)~~(14)~~ The application of this law to commercial property and commercial casualty insurance, which includes commercial umbrella liability insurance, ceases on January 1, 1997.

Section 2. Subsection (4) of section 628.6017, Florida Statutes, is amended to read:

628.6017 Converting assessable mutual insurer.—

(4) An assessable mutual insurer becoming a stock insurer or a nonassessable mutual insurer shall not be subject to s. 627.215 or s. 627.351(5) for 5 years following authorization of the conversion by the office. However, the converted stock insurer or nonassessable mutual insurer shall file all necessary data required by s. 627.215. Such amounts otherwise subject to s. 627.215(8) ~~627.215(10)~~ shall be maintained as surplus as to policyholders and not be available for dividends for a period of 5 years.

Section 3. This act shall take effect July 1, 2012.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 4181 Workers' Compensation
SPONSOR(S): Caldwell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Reilly	Cooper
2) Economic Affairs Committee			

SUMMARY ANALYSIS

Under the workers' compensation system, health care providers that treat injured workers must be certified by the Department of Financial Services (DFS) to be eligible to receive reimbursement. The certification process includes the completion and submission of a "Health Care Provider Application for Certification," accompanied by proof of possession of a valid license issued by the Department of Health.

The bill repeals the certification requirement for health care providers in the workers' compensation system. As such providers are licensed by the Department of Health, the DFS believes that subsequent certification is redundant and is of no additional value.

The DFS informs that the bill will result in the reduction of 1 FTE and annual savings of $40,187.

The bill is effective on July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Chapter 440, F.S., Florida's Workers' Compensation Law, requires health care providers to be certified by the Department of Financial Services (DFS) to be eligible for reimbursement for services rendered to injured workers.[1] The certification process includes the completion and submission of a "Health Care Provider Application for Certification" (Form DFS-3160-0020), accompanied by proof of possession of a valid license issued by the Department of Health.[2,3]

Effect of the Bill

The bill repeals the requirement that health care providers in the workers' compensation system be certified by the DFS to be eligible for reimbursement for services rendered. As such providers are already licensed by the Department of Health, the DFS states that subsequent certification is redundant and of no utility to the workers' compensation system.[4]

B. SECTION DIRECTORY:

Section 1. Amends s. 440.13, F.S., to eliminate the requirement that health care providers in the workers' compensation system be certified by the DFS; removes references within the Workers' Compensation Law to certified providers.

Section 2. Amends s. 440.102, F.S., to conform a cross reference.

Section 3. Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DFS informs that the bill will result in the reduction of 1 FTE and annual savings of $40,187.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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[1] Section 440.13(1)(d), F.S.

[2] *See* Rule 69L-29.002, F.A.C., "Requirements for Certification." An overview of the certification process, "Certification as a Health Care Provider," is also available on the DFS website at http://www.myfloridacfo.com/wc/ (Last accessed January 26, 2011).

[3] The requirement that physicians also complete a five-hour course on cost containment, utilization control, and other topics to obtain certification was removed by ch. 2001-91, L.O.F. The health care provider application form, however, has not been amended to reflect this change.

[4] DFS analysis of HB 4181 dated January 23, 2012, on file with staff of the Insurance & Banking Subcommittee.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill reduces the regulatory burden on health care providers that seek to participate in the workers' compensation system by eliminating an unnecessary certification process.

D. FISCAL COMMENTS:

None.

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 an 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 a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The DFS informs that, if enacted into law, the bill will require repeal of Rule 69L-29, FAC.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; deleting the definition of the term "certified health care provider"; deleting provisions providing for removal of physicians from lists of those authorized to render medical care under certain conditions; conforming provisions to changes made by the act; amending s. 440.102, F.S.; revising a cross-reference to conform to changes made by the act; providing an effective date.

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

Section 1. Paragraphs (e) through (t) of subsection (1) of section 440.13, Florida Statutes, are redesignated as paragraphs (d) through (s), respectively, subsections (14) through (17) of that section are renumbered as subsections (13) through (16), respectively, and present paragraphs (d), (h), and (q) of subsection (1), paragraphs (a), (c), (e), and (i) of subsection (3), paragraph (b) of subsection (8), paragraph (e) of subsection (12), subsection (13), and paragraph (a) of present subsection (14) of that section, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

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

~~(d) "Certified health care provider" means a health care provider who has been certified by the department or who has entered an agreement with a licensed managed care organization~~

~~to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance.~~

(g) ~~(h)~~ "Health care provider" means a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician ~~and who has been certified by the department as a health care provider~~. The term "health care provider" includes a health care facility.

(p) ~~(q)~~ "Physician" or "doctor" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466~~, each of whom must be certified by the department as a health care provider~~.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services ~~must be a certified health care provider and~~ must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. ~~The department shall adopt rules to implement the certification of health care providers.~~

(c) A health care provider may not refer the employee to

another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral ~~must be to a health care provider that has been certified by the department~~, unless the referral is for emergency treatment, ~~and the referral~~ must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. Such procedures shall be for a health care provider ~~certified~~ under this section.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized ~~or certified~~, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not

compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(b) If the department determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the department, including a pattern or practice of providing treatment in excess of the practice parameters or protocols of treatment, it may impose one or more of the following penalties:

1. An order of the department barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

~~4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;~~

4.~~5.~~ An administrative fine assessed by the department in an amount not to exceed $5,000 per instance of overutilization or violation; and

5.~~6.~~ Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(e) In addition to establishing the uniform schedule of

maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to ~~certified~~ health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey ~~certified~~ health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel.

~~(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED~~

~~TO RENDER MEDICAL CARE.~~ ~~The department shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:~~

~~(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;~~

~~(b) Exceeded the limits of his or her or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or her or its qualifications in his or her application;~~

~~(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or her or its findings to the employer or carrier as required under this chapter;~~

~~(d) Solicited, or employed another to solicit for himself or herself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;~~

~~(e) Refused to appear before, or to answer upon request of, the department or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;~~

~~(f) Self-referred in violation of this chapter or other laws of this state; or~~

~~(g) Engaged in a pattern of practice of overutilization or~~

~~a violation of this chapter or rules adopted by the department, including failure to adhere to practice parameters and protocols established in accordance with this chapter.~~

(13)~~(14)~~ PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider ~~certified and~~ authorized to render remedial treatment, care, or attendance under this chapter. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter. Payment to health care providers or physicians shall be subject to the medical fee schedule and applicable practice parameters and protocols, regardless of whether the health care provider or claimant is asserting that the payment should be made.

Section 2. Paragraph (p) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(p) All authorized remedial treatment, care, and

attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self-insurer. However, the carrier or self-insurer must have given reasonable notice to all affected health care providers that payment for treatment, care, and attendance provided to the employee after a future date certain will be denied. A health care provider, as defined in s. 440.13(1)(g) ~~440.13(1)(h)~~, that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. This act shall take effect July 1, 2012.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1277 Money Services Businesses
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Barnum	Cooper

SUMMARY ANALYSIS

In 2011, the Chief Financial Officer convened the Money Service Business Facilitated – Workers' Compensation Work Group to study the issue of workers' compensation premium fraud in Florida, as facilitated by check cashers, and develop recommendations to resolve the issue. The fraud makes possible avoidance of tax collections by the state, results in underpayment of workers compensation insurance premiums to the carriers, and places law-abiding contractors at a competitive disadvantage when competing, on a price basis, with contractors benefitting from the fraud.

The Office of Financial Regulations (OFR) is responsible for licensing money services businesses. There are currently 1,065 licensed businesses having authority to engage in check cashing. Customer files, documentation, and records are reviewed during an examination or investigation by the OFR. Under current law, an examination must be conducted within 6 month of a license being issued, and then at least every 5 years. Because of the OFR's workload and limited assets, after the initial examination, a licensee can assume, with reasonable certainty, that it will not be examined again for several years, and knows that it will be provided advance notice. Thus, those conducting illegal activities are able to hide, destroy, or tamper with pertinent records or materials.

Check cashers who negotiate suspect checks may encounter difficulties in having their own financial institutions honor the checks, and in turn, credit their accounts. This incentivizes some check cashing facilities to sell checks that their financial institutions will not honor. Selling of payment instruments within 5 business days after acceptance is permissible under current law. When money service businesses do not properly negotiate, endorse, or deposit checks, it may be difficult for the OFR to detect irregularities or illegalities.

The bill eliminates the requirement that the OFR provide a 15-day advance notice to money services business licensees prior to conducting an examination or investigation. This change reduces the opportunity for hiding, destroying, or otherwise tampering with records and materials which may be pertinent to the OFR's examination or investigation. While retaining the requirement that each licensee be examined at least once every 5 years, the bill eliminates the requirement that the OFR conduct an examination of a business within 6 months of the business becoming licensed. This will provide greater flexibility to the OFR by permitting use of its resources in a more targeted manner. Both changes reduce the predictability of when a business may be examined.

The bill requires that a check cashing business deposit payment instruments into its own commercial account at a federally insured financial institution and deletes the authorization to sell payment instruments within 5 business days after acceptance. Audit trails and tracking of moneys are facilitated by requiring that the deposit of all payment instruments be made into the business's own account.

The bill authorizes disciplinary action and provides for penalties should a check casher fail to maintain a depository account in its own name, or fail to deposit all payment instruments into its own account.

The bill stipulates that a check casher may only accept or cash a payment instrument from a person who is the original payee or a conductor who is an authorized officer of the corporate payee named on the instrument's face. Acceptance and cashing of third-party checks is no longer authorized.

The bill codifies the $5 verification fee currently established by rule.

The bill has an indeterminate positive impact on state government and no impact on local government.

The bill provides for an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background:

In 2008, the Attorney General impaneled the Eighteenth Statewide Grand Jury to look into the issue of fraudulent insurance and other organized criminal enterprises. In March 2008, it published the Second Interim Report of the Statewide Grand Jury entitled "Check Cashers: A Call for Enforcement." As a result, Ch. 560, F.S., Money Services Business, underwent a major re-write to address concerns with fraudulent insurance and money laundering activities. While the reforms were positive, the legislation did not cure the problem of facilitators creating shell companies for the purpose of purchasing workers compensation insurance policies and then, for a fee, allowing uninsured contractors to use those certificates of insurance.

In 2011, the Chief Financial Officer convened the Money Service Business Facilitated – Workers' Compensation Work Group to study the issue of workers' compensation premium fraud in Florida, as facilitated by check cashers, and develop recommendations to resolve the issue. It was comprised of representatives from state government and industry stakeholders. A report containing the work group's recommendations and other relevant materials are available online.[1]

Workers' compensation insurance fraud continues to be a problem within Florida's construction industry. The scheme involves facilitators, contractors, and money services businesses. Facilitators create fake shell companies, typically incorporated online through the Department of State, so as to avoid true review and verification. The shell companies then purchase a minimal workers' compensation insurance policy, usually by describing its operations as a two to four person company. The facilitator may then approach an uninsured subcontractor who is looking for work but lacks the valid workers' compensation policy necessary to obtain contracts from a general contractor. The facilitator makes the shell company's name and workers' compensation policy available for use by the uninsured subcontractor, for a fee. Subsequently, a general contractor, knowingly or unknowingly, uses the uninsured subcontractor to perform work.

Once the uninsured subcontractor completes work under the guise of the shell company, payment will be made to him/her from the general contractor via company check made payable to the shell company. Typically, the check cannot be cashed at a bank because most banks will not cash a check made payable to a business or third party, but rather will require that the check be deposited into the payee's bank account. However, money service businesses will allow the cashing of the third-party business-to-business checks by certain "authorized" persons related to the payee. These "authorized" persons are the facilitator and others designated by the facilitator. Many times, these people have been introduced to the money service business' employees in advance, and limited powers of attorney listing these "authorized" persons are found in the "Know Your Customer" files of the money service business's records.

When checks made payable to the shell company are negotiated at the complicit money services business, two fees are taken out. One, usually between 1.5% and 2%, is taken out for the money services business as the fee for cashing the check. The second fee, usually between 6% and 8%, is taken out for the facilitator, as the fee for use of the shell company's name and workers' compensation insurance policy. The balance of the check is then returned to the uninsured subcontractor, posing as the shell company, in cash. The money paid in this manner is not reported to the shell company's workers' compensation insurance carrier, effectively avoiding the payment of any workers' compensation premiums or applicable payroll taxes. The payments are not considered payroll exposure because, on paper, the transaction appears to be a legitimate contractor to insured subcontractor payment.

[1] http://www.myfloridacfo.com/sitePages/agency/sections/MoneyServiceBusiness.aspx (Last visited on January 26, 2012).

Some money service businesses are at least tacitly aware of the fraud and their role in its success. Complicit money service businesses falsify required documents regarding the true identity of those persons authorized to conduct the transactions. To do this, they will complete Currency Transaction Reports for transactions in excess of $10,000 in the name of the owner of the shell company, rather than the facilitator, to protect the latter's identity.

Facilitators may duplicate this scheme multiple times using the same workers' compensation insurance policy. Upon becoming concerned with detection, they close the shell company, which only exists on paper, and form a new entity. Shell company documentation often reflects questionable information, such as an owner who does not exist or is in the country illegally. Therefore, it is difficult link these fraudulent activities.

Uninsured subcontractors, by avoiding actual workers' compensation premiums, are able to pass that cost savings on to general contractors, some of whom may be complicit in this fraud. Contractors and subcontractors who are in compliance with the state's workers' compensation insurance laws are placed at a competitive disadvantage when competing, on a price basis, with contractors benefitting from the fraud.

These fraudulent activities make possible avoidance of tax collection by the state. They result in underpayment of workers compensation insurance premiums to the carriers. Additionally, when an uninsured worker is injured, the costs are ultimately paid for by all taxpayers.

Current Situation:

The Office of Financial Regulations (OFR) is responsible for licensing money services businesses. There are currently 1,065 licensed businesses having authority to engage in check cashing.[2] Current law provides that the requirement for licensure does not apply to a person cashing payment instruments that have an aggregate face value of less than $2,000 per person per day and that are incidental to the retail sale of goods or services, within certain parameters. The $2,000 benchmark was selected in 2008 after conversations with interested parties including representatives from Jackson Hewitt, Wal-Mart, Amscot Financial, Inc., and others. The $2,000 amount was felt to still provide protection against fraudulent insurance and money laundering activities, and was consistent with the IRS's reported average federal tax refund.

There are no federal regulations which require a bank to cash a check for an individual who does not have an account with that bank. A 2009 Federal Deposit Insurance Corporation national survey of unbanked and underbanked household reported that an estimated 7.7% of U.S. households do not have a checking or savings account. According to the survey, 527,000 or 7% of Florida's households are unbanked.[3]

Check cashers are limited in the fees they may charge. By law, a check casher may not charge fees:

- In excess of 5% of the face amount of the payment instrument, or $5, whichever is greater.
- In excess of 3% of the face amount of the payment instrument, or $5, whichever is greater, if the payment instrument is any kind of state public assistance or federal social security benefit.
- For personal checks or money orders in excess of 10% of the face amount of those payment instruments, or $5, whichever is greater.[4]

Check cashers are authorized to collect a fee linked to the direct costs of verifying such things as a customer's identity or employment. That fee, established by rule, may not exceed $5.[5]

Documentation and record keeping requirements for Florida-licensed check cashers are established in law. These specify that, for any payment instrument accepted having a face value of $1,000 or more,

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[2] Office of Financial Regulation HB 1277 Bill Analysis dated January 20, 2012, on file with the Insurance & Banking Subcommittee.
[3] http://www.fdic.gov/householdsurvey (Last visited on January 26, 2012).
[4] s. 560.309(8), F.S.
[5] 69V-560.801, F.A.C.

the check casher must maintain a copy of the personal identification that bears a photograph of the customer used as identification and a thumbprint of the customer taken by the licensee. Licensees are required to affix customer thumbprints to the original of each payment instrument exceeding $1,000, as well as secure and maintain a copy of the original payment instrument, a copy of the customer's personal identification presented at the time of acceptance, and maintain customer files for those cashing a corporate and third party payment instrument. Those customer files must include documentation from the Secretary of State verifying the corporate registration, Articles of Incorporation, information from the Department of Financial Services Compliance Proof of Coverage Query Page, and documentation of those authorized to negotiate payment instruments on the corporation's behalf. The files must be updated annually. Record keeping requirements for check cashers when the payment instrument is $1,000 or more, at a minimum, must include:

- Transaction date.
- Payor name.
- Payee name.
- Conductor name, if other than the payee.
- Amount of payment instrument.
- Amount of currency provided.
- Type of payment instrument.
- Fee charged for the cashing of the payment instrument.
- Branch/Location where instrument was accepted.
- Identification type presented by conductor.
- Identification number presented by conductor.

It is required that logs of these transactions be maintained in an electronic format that is readily retrievable and capable of being exported to most widely available software applications including Microsoft EXCEL.[6]

Customer files, documentation, and records are reviewed during an examination or investigation by the OFR. By law, an examination must be conducted within 6 months of a license being issued, and then at least every 5 years.[7] With few exceptions, the OFR is required to provide at least 15 days' notice to a money services business prior to conducting an examination or investigation.[8] Thus, those conducting illegal activities are able to hide, destroy, or tamper with pertinent records or materials. Because of the OFR's workload and limited assets, after the initial examination, a licensee can assume, with reasonable certainty, that it will not be examined again for several years and, when the examination or investigation does occur, it will receive advance notice.

Check cashers who negotiate suspect checks may encounter difficulties in having their financial institutions honor the checks, and in turn, credit their accounts. This incentivizes some check cashing facilities to sell checks that their financial institutions will not honor. Selling of payment instruments within 5 business days after acceptance is permissible under current law.[9] When money service businesses do not properly negotiate, endorse, or deposit checks, it may be difficult for the OFR to detect irregularities or illegalities.[10]

Effect of the bill:

The bill eliminates the requirement that the OFR provide a 15-day advance notice to money services business licensees prior to conducting an examination or investigation. This change reduces the opportunity for hiding, destroying, or otherwise tampering with records and materials which may be pertinent to the OFR's examination or investigation. While retaining the requirement that each licensee be examined at least once every 5 years, the bill eliminates the requirement that the OFR conduct an examination of a business within 6 months of the business becoming licensed. This will provide greater

[6] 69V-560.704 F.A.C.
[7] *Id.*
[8] s. 560.109(1), F.S.
[9] s. 560.309(3), F.S.
[10] *A Report by the Money Services Business Facilitated Workers' Compensation Fraud Work Group*

flexibility to the OFR by permitting use of its resources in a more targeted manner. Both changes reduce the predictability of when a business may be examined.

The bill requires that a check cashing business deposit payment instruments into its own commercial account at a federally insured financial institution and deletes the authorization to sell payment instruments within 5 business days after acceptance. Audit trails and tracking of moneys are facilitated by requiring that the deposit of all payment instruments be made into the business's own account. Maintaining such an account is a prerequisite for continued operation. A licensee is required to notify the OFR within 5 business days after it ceases to maintain a commercial depository account in its own name and, before resuming check cashing, must reestablish such an account and notify the OFR that the account exists.

The bill authorizes disciplinary action and provides for penalties should a check casher fail to maintain a depository account in its own name, or fail to deposit all payment instruments into its own account. Possible disciplinary actions include denial, revocation, or suspension of a license. In addition, it provides a definition for "fraudulent identification paraphernalia"[11] and specifies that that possession and use of fraudulent identification paraphernalia is a prohibited act punishable as a felony of the third degree.

The bill stipulates that a check casher may only accept or cash a payment instrument from a person who is the original payee or a conductor who is an authorized officer of the corporate payee named on the instrument's face. Acceptance and cashing of third-party checks is no longer authorized.

The bill codifies the $5 fee, currently established by rule, which is linked to the direct cost of verifying such things as a customer's identity or employment.

The bill provides for an effective date of July 1, 2012.

B. SECTION DIRECTORY:

Section 1: Amends s. 560.103, F.S., relating to definitions.

Section 2: Amends s. 560.109, F.S., relating to examinations and investigations.

Section 3: Amends s. 560.111, F.S., relating to prohibited acts.

Section 4 Reenacts and amends s. 560.114, F.S., relating to disciplinary action penalties.

Section 5: Amends s. 560.126, F.S., relating to required notice by licensee.

Section 6: Amends s. 560.309, F.S., relating to conduct of business.

Section 7: Amends s. 560.310, F.S., relating to records of check cashers and foreign currency exchangers.

Section 8: Provides an effective date of July 1, 2012.

[11] "Fraudulent identification paraphernalia" means all equipment, products, or materials of any kind that are used, intended for use, or designed for use in the misrepresentation of a customer's identity. The term includes a signature or thumbprint stamp, blank, stolen, counterfeit, or unlawfully issued personal identification.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate. There may be an increase in tax revenue as underpayment of workers' compensation insurance premium and falsified reporting of payroll are reduced.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

- Elimination of the competitive advantage resulting from use of subcontractors without workers' compensation insurance may result in additional business for law-abiding contractors.
- By ensuring all appropriate individuals are covered by workers compensation insurance, the cost of care for the uninsured, which is ultimately paid for by all taxpayers, may be reduced.

D. FISCAL COMMENTS:

None.

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 an 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 a 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 money services businesses; amending s. 560.103, F.S.; defining terms for purposes of provisions regulating money services businesses; amending s. 560.109, F.S.; revising the frequency and notice requirements for examinations and investigations by the Office of Financial Regulation of money services business licensees; amending s. 560.111, F.S.; prohibiting money services businesses, authorized vendors, and affiliated parties from possessing certain paraphernalia used or intended or designed for use in misrepresenting a customer's identity, for which penalties apply; prohibiting certain persons from providing a customer's personal identification information to a money services business licensee and providing penalties; reenacting s. 560.114(1)(h), F.S., relating to penalties for certain prohibited acts by money services businesses, to incorporate amendments made to the act; amending s. 560.114, F.S.; prohibiting certain acts by money services businesses, authorized vendors, and affiliated parties, for which penalties apply; revising the conditions for which a money services business license may be suspended; amending ss. 560.126 and 560.309, F.S.; requiring a money services business licensee to maintain its own federally insured depository account and deposit into the account any payment instruments cashed; requiring a

licensee to notify the office and cease to cash payment instruments if the licensee ceases to maintain the account; prohibiting a licensee from accepting or cashing a payment instrument from a person who is not the original payee; establishing a limit on the amount of fees that licensees may charge for the direct costs of verification of payment instruments cashed; amending s. 560.310, F.S.; revising requirements for the records that a money services business licensee must maintain related to the payment instruments cashed; providing an effective date.

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

Section 1. Subsections (9) and (10) of section 560.103, Florida Statutes, are renumbered as subsections (11) and (12), respectively, present subsections (11) through (14) are renumbered as subsections (14) through (17), respectively, present subsections (15) through (27) are renumbered as subsections (19) through (31), respectively, present subsections (28) through (30) are renumbered as subsections (33) through (35), respectively, and new subsections (9), (10), (13), (18), (32), and (36) are added to that section, to read:

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

(9) "Conductor" means a natural person who presents himself or herself to a licensee for purposes of cashing a payment instrument.

(10) "Corporate payment instrument" means a payment

instrument on which the payee named on the instrument's face is other than a natural person.

(13) "Department" means the Department of Financial Services.

(18) "Fraudulent identification paraphernalia" means all equipment, products, or materials of any kind that are used, intended for use, or designed for use in the misrepresentation of a customer's identity. The term includes, but is not limited to:

(a) A signature stamp, thumbprint stamp, or other tool or device used to forge a customer's personal identification information.

(b) An original of any type of personal identification listed in s. 560.310(2)(b) which is blank, stolen, or unlawfully issued.

(c) A blank, forged, fictitious, or counterfeit instrument in the similitude of any type of personal identification listed in s. 560.310(2)(b) which would in context lead a reasonably prudent person to believe that such instrument is an authentic original of such personal identification.

(d) Counterfeit, fictitious, or fabricated information in the similitude of a customer's personal identification information that, although not authentic, would in context lead a reasonably prudent person to credit its authenticity.

(32) "Personal identification information" means a customer's name that, alone or together with any of the following information, may be used to identify that specific customer:

(a) Customer's signature.

(b) Photograph, digital image, or other likeness of the customer.

(c) Unique biometric data, such as the customer's thumbprint or fingerprint, voice print, retina or iris image, or other unique physical representation of the customer.

Section 2. Subsections (1) and (7) of section 560.109, Florida Statutes, are amended to read:

560.109 Examinations and investigations.—The office may conduct examinations and investigations, within or outside this state to determine whether a person has violated any provision of this chapter and related rules, or of any practice or conduct that creates the likelihood of material loss, insolvency, or dissipation of the assets of a money services business or otherwise materially prejudices the interests of their customers.

(1) The office may, without advance notice, examine or investigate each licensee as often as is warranted for the protection of customers and in the public interest. However, the office must examine each licensee~~, but~~ at least once every 5 years. ~~A new licensee shall be examined within 6 months after the issuance of the license. The office shall provide at least 15 days' notice to a money services business, its authorized vendor, or license applicant before conducting an examination or investigation. However,~~ The office may, without advance notice, examine ~~conduct an examination~~ or investigate ~~investigation of~~ a money services business, authorized vendor, ~~or~~ affiliated party, or license applicant at any time ~~and without advance notice~~ if

the office suspects that the money services business, authorized vendor, ~~or~~ affiliated party, or license applicant has violated or is about to violate any provision ~~provisions~~ of this chapter or any criminal law ~~laws~~ of this state or of the United States.

(7) Reasonable and necessary costs incurred by the office or third parties authorized by the office in connection with examinations or investigations may be assessed against any person subject to this chapter on the basis of actual costs incurred. Assessable expenses include, but are not limited to, expenses for: interpreters; certified translations of documents into the English language required by this chapter or related rules; communications; legal representation; economic, legal, or other research, analyses, and testimony; and fees and expenses for witnesses. The failure to reimburse the office is a ground for denial of a license application, denial of a license renewal, or for revocation of any approval thereof. Except for examinations authorized under this section ~~s. 560.109~~, costs may not be assessed against a person unless the office determines that the person has operated or is operating in violation of this chapter.

Section 3. Paragraph (g) is added to subsection (1) of section 560.111, Florida Statutes, subsection (3) is renumbered as subsection (4), present subsection (4) is renumbered as subsection (5) and amended, and a new subsection (3) is added to that section, to read:

560.111 Prohibited acts.—

(1) A money services business, authorized vendor, or affiliated party may not:

(g) Knowingly possess any fraudulent identification paraphernalia. This paragraph does not prohibit the maintenance and retention of any records required by this chapter.

(3) A person other than the conductor of a payment instrument may not provide a licensee engaged in cashing the payment instrument with the customer's personal identification information.

(5)~~(4)~~ Any person who willfully violates any provision of s. 560.403, s. 560.404, or s. 560.405 commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 4. Paragraph (h) of subsection (1) of section 560.114, Florida Statutes, is reenacted, paragraphs (aa)and (bb) are added to that subsection, and subsection (2) of that section is amended, to read:

560.114 Disciplinary actions; penalties.—

(1) The following actions by a money services business, authorized vendor, or affiliated party constitute grounds for the issuance of a cease and desist order; the issuance of a removal order; the denial, suspension, or revocation of a license; or taking any other action within the authority of the office pursuant to this chapter:

(h) Engaging in an act prohibited under s. 560.111.

(aa) Failure of a check casher to maintain a federally insured depository account as required by s. 560.309.

(bb) Failure of a check casher to deposit into its own federally insured depository account any payment instrument cashed as required by s. 560.309.

(2) The office may immediately suspend the license of any money services business if the money services business fails to:

(a) Provide to the office, upon written request, any of the records required by s. ~~ss.~~ 560.123, s. 560.1235, s. 560.211, or s. ~~and~~ 560.310 or any rule adopted under those sections. The suspension may be rescinded if the licensee submits the requested records to the office.

(b) Maintain a federally insured depository account as required by s. 560.309.

For purposes of s. 120.60(6), failure to perform ~~provide~~ any of the acts specified in this subsection ~~above-mentioned records~~ constitutes immediate and serious danger to the public health, safety, and welfare.

Section 5. Subsection (4) is added to section 560.126, Florida Statutes, to read:

560.126 Required notice by licensee.—

(4) A licensee that engages in check cashing must notify the office within 5 business days after the licensee ceases to maintain a federally insured depository account as required by s. 560.309(3) and, before resuming check cashing, must reestablish such an account and notify the office of the account.

Section 6. Subsections (3), (4), and (8) of section 560.309, Florida Statutes, are amended to read:

560.309 Conduct of business.—

(3) A licensee under this part must maintain and deposit payment instruments into its own ~~a~~ commercial account at a

federally insured financial institution. If a licensee ceases to maintain such a depository account, the licensee must not engage in check cashing until the licensee reestablishes such an account and notifies the office of the account as required by s. 560.126(4) ~~or sell payment instruments within 5 business days after the acceptance of the payment instrument~~.

(4) A licensee may not accept or cash a ~~multiple~~ payment instrument ~~instruments~~ from a person who is not the original payee; however, this subsection does not prohibit a licensee from accepting or cashing a corporate payment instrument from a conductor who is an authorized officer of the corporate payee named on the instrument's face~~, unless the person is licensed to cash payment instruments pursuant to this part and all payment instruments accepted are endorsed with the legal name of the person~~.

(8) Exclusive of the direct costs of verification, which shall be established by rule not to exceed $5, a check casher may not:

(a) Charge fees, except as otherwise provided by this part, in excess of 5 percent of the face amount of the payment instrument, or $5, whichever is greater;

(b) Charge fees in excess of 3 percent of the face amount of the payment instrument, or $5, whichever is greater, if such payment instrument is the payment of any kind of state public assistance or federal social security benefit payable to the bearer of the payment instrument; or

(c) Charge fees for personal checks or money orders in excess of 10 percent of the face amount of those payment

instruments, or $5, whichever is greater.

Section 7. Section 560.310, Florida Statutes, is amended to read:

560.310 Records of check cashers and foreign currency exchangers.—

(1) ~~In addition to the record retention requirements specified in s. 560.1105,~~ A licensee engaged in check cashing must maintain for the period specified in s. 560.1105 a copy of each payment instrument cashed.

(2) If the payment instrument exceeds $1,000, the following additional information must be maintained ~~the following~~:

(a) Customer files, as prescribed by rule, on all customers who cash corporate ~~or third-party~~ payment instruments that exceed ~~exceeding~~ $1,000.

(b) ~~For any payment instrument accepted having a face value of $1,000 or more:~~

~~1.~~ A copy of the personal identification that bears a photograph of the customer used as identification and presented by the customer. Acceptable personal identification is limited to a valid driver ~~driver's~~ license; a state identification card issued by any state of the United States or its territories or the District of Columbia, and showing a photograph and signature; a United States Government Resident Alien Identification Card; a passport; or a United States Military identification card.

(c)~~2.~~ A thumbprint of the customer taken by the licensee when the payment instrument is presented for negotiation or

payment.

(d) ~~(c)~~ A payment instrument log that must be maintained electronically as prescribed by rule. For purposes of this paragraph, multiple payment instruments accepted from any one person on any given day which total $1,000 or more must be aggregated and reported on the log.

(3) ~~(2)~~ A licensee under this part may engage the services of a third party that is not a depository institution for the maintenance and storage of records required by this section if all the requirements of this section are met.

Section 8. This act shall take effect July 1, 2012.