Tab 1	**SB 892** by **Harrell**; (Similar to CS/H 01219) Dental Insurance Claims

642356	A	S	RCS	BI, Harrell	Delete L.90 - 307:	02/08 01:25 PM

Tab 2	**SB 964** by **Calatayud**; (Compare to CS/H 00885) Coverage of Biomarker Testing

237278	D	S	RCS	BI, Calatayud	Delete everything after	02/08 01:25 PM

Tab 3	**SB 1064** by **Powell**; (Similar to CS/H 00923) Wills and Estates

862428	A	S	RCS	BI, Powell	Delete L.61 - 151:	02/08 01:25 PM

Tab 4	**SB 1338** by **DiCeglie**; (Similar to CS/H 01465) Pet Insurance

159918	D	S	RCS	BI, DiCeglie	Delete everything after	02/08 01:25 PM

Tab 5	**SB 1366** by **DiCeglie**; (Similar to CS/H 01029) My Safe Florida Condominium Pilot Program

450856	A	S	RCS	BI, DiCeglie	Delete L.67 - 150:	02/08 01:25 PM

Tab 6	**SB 1640** by **Collins**; (Compare to CS/H 01549) Payments for Health Care Services

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Boyd, Chair
Senator DiCeglie, Vice Chair

MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Boyd, Chair; Senator DiCeglie, Vice Chair; Senators Broxson, Burton, Hutson, Ingoglia, Mayfield, Powell, Thompson, Torres, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 892** Harrell (Similar CS/H 1219)	Dental Insurance Claims; Prohibiting a contract between a health insurer and a dentist from containing certain restrictions on payment methods; prohibiting a health insurer from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization, etc. BI 02/06/2024 Fav/CS AEG FP	Fav/CS Yeas 10 Nays 0
2	**SB 964** Calatayud (Compare CS/H 885)	Coverage of Biomarker Testing; Requiring the Agency for Health Care Administration to provide specified coverage of biomarker testing under the Medicaid program; requiring managed care plans under contract with the agency to provide coverage of biomarker testing in a specified manner; requiring that certain health insurance policies and health maintenance contracts, respectively, provide specified coverage of biomarker testing; requiring that such coverage be provided in a manner that limits disruption in care, etc. BI 02/06/2024 Fav/CS AHS FP	Fav/CS Yeas 9 Nays 0
3	**SB 1064** Powell (Similar CS/H 923)	Wills and Estates; Expanding the types of probate documents that must be recorded; specifying that certain property is either included or excluded from the probate estate at the time of death; defining the term “probate estate”; providing that demands and disputes arising under a certain act must be determined using a specified action; providing that certain rights are forfeited if specified actions are not taken, etc. JU 01/29/2024 Favorable BI 02/06/2024 Fav/CS RC	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1338** DiCeglie (Similar CS/H 1465)	Pet Insurance; Citing this act as the "Pet Insurance Act"; requiring pet insurers to use certain terms as defined in this act and include such definitions in their policies and on their website or on their program administrator's website; specifying requirements for pet insurers that determine claim payments based on usual and customary fees; prohibiting pet insurers and insurance producers from marketing a wellness program as pet insurance; prohibiting insurance producers from selling, soliciting, or negotiating a pet insurance product unless the producer is licensed and has completed certain training, etc. BI 02/06/2024 Fav/CS AEG FP	Fav/CS Yeas 11 Nays 0
5	**SB 1366** DiCeglie (Similar CS/H 1029)	My Safe Florida Condominium Pilot Program; Establishing the My Safe Florida Condominium Pilot Program within the Department of Financial Services; providing requirements for associations and unit owners to participate in the pilot program; requiring the department to contract with specified entities for certain inspections; providing requirements for hurricane mitigation inspectors and inspections, etc. BI 02/06/2024 Fav/CS RI AP	Fav/CS Yeas 11 Nays 0
6	**SB 1640** Collins (Compare H 1549, S 1502)	Payments for Health Care Services; Establishing a 3-year statute of limitations for an action to collect medical debt for services rendered by certain health care facilities; providing additional personal property exemptions from legal process for medical debts resulting from services provided in certain licensed facilities; requiring certain licensed facilities to post on their respective websites a consumer-friendly list of standard charges for a minimum number of shoppable health care services, etc. BI 02/06/2024 Favorable FP	Favorable Yeas 9 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 892
INTRODUCER:	Banking and Insurance Committee and Senator Harrell
SUBJECT:	Dental Insurance Claims
DATE:	February 8, 2024 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 892 revises provisions within the Florida Insurance Code relating to covered dental services, contractual agreements, and dental claims payments by an insurer, prepaid limited health service organization (PLHSO), or a health maintenance organization (HMO). The bill provides the following changes:

- Revises the definition of covered services, and as a result, if an insurer, HMO, or PLHSO denies service due to a contractual limitation (maximum benefits paid prior to the end of the plan year), then the procedure would be considered a non-covered service and the dentist would not be subject to the negotiated rate, and may charge patient a higher rate.
- Prohibits a contract between a dentist and a health insurer, HMO or PLHSO from limiting the method of claim payments for dental services to credit card payments only.
- Requires a health insurer, PLHSO, or HMO to disclose in writing to a dentist any fees associated with an electronic funds transfer (EFT) and alternative payment methods at least 10 days before the insurer, HMO or PLHSO pays a dentist via EFT.
- Prohibits an insurer, HMO or PLHSO that pays a claim to a dentist through Automatic Clearing House (ACH) from charging a fee solely to transmit the payment unless the dentist has consented to the fee.
- Limits circumstances in which an insurer, HMO, or PLHSO may deny the payment of a claim if the procedure was previously authorized by an insurer, HMO, or PLHSO prior to the dentist rendering the service. These circumstances include:
  - Benefit limitations being reached subsequent to the issuance of the prior authorization.

- Inadequate documentation submitted by a dentist to support the originally authorized procedures and claim.
- Changes in the insured's condition or new procedures are provided to the insured subsequent to the issuance of the prior authorization.
- The denial of the dental service claim was due another payor being responsible for payment or the dentist has already been paid for the procedures identified in the claim.
- The person receiving the procedure was not eligible to receive the procedure on the date of service and the insurer, HMO, or PLHSO did not know of the ineligibility.

The fiscal impact of the bill on State Group Insurance is unknown.

II. Present Situation:

State Regulation of Insurance

The Office of Insurance Regulation (OIR),[1] is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[2] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[3] The Agency for Health Administration (Agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the Agency.[4] As part of the certification process used by the Agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[5]

Statutory Cost Containment Requirements

Insurers or HMOs use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, insurers or HMOs may place utilization management requirements on the use of certain medical treatments or drugs on their formulary.

Section 627.4234, F.S., requires a health insurance policy or health care services plan, which provides medical, hospital, or surgical expense coverage delivered or issued for delivery in this state to contain one or more of the following procedures or provisions to contain health insurance costs or mitigate cost increases:

- Coinsurance.
- Deductible amounts.
- Utilization review.

[1] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.
[2] Section 20.121(3)(a), F.S.
[3] Sections 624.401 and 641.49, F.S.
[4] Section 641.495, F.S.
[5] *Id.*

- Audits of provider bills to verify that services and supplies billed were furnished and that proper charges were made.
- Scheduled benefits.
- Benefits for preadmission testing.
- Any lawful measure or combination of measures for which the insurer provides to the office information demonstrating that the measure or combination of measures is reasonably expected to have an effect toward containing health insurance costs or cost increases.

Denial of Claims

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to the provision of the procedure. The full claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

There are many possible reasons for claim denials.[6] Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary. Denied claims[7] may be appealed.

After an insurer or HMO pays a claim, the insurer or HMO may conduct a claims audit to verify claims were paid appropriately and accurately. Such an audit can be triggered by a variety of reasons.[8] Some of these situations include new billing guidelines have been established by regulators; the provider has made significant changes to the original bill, such as the diagnosis of the patient; the plan is notified that the enrollee's coverage is terminated due to non-payment of premiums; or the plan is notified that the enrollee has other health insurance coverage. After the audit, an insurer or HMO may retrospectively deny a claim for a preauthorized service and try to recoup the payment from the provider. Reasons for the retroactive denial may include fraud, submission of incomplete or inaccurate information; nonpayment of premiums; exhaustion of benefits; coordination of benefits; or if the individual was not enrolled or eligible for coverage at the time services were rendered.[9] As a result, an insurer or HMO may try to recoup payment from a provider by retroactively denying a previously paid claim.

Group Health Plans Retroactive Termination of Coverage

Retroactive termination of insurance coverage to an earlier date due to an employee's discharge is an increasing problem for some providers and consumers. Some plans may allow an employer to cancel coverage of an employee retroactively more than 90 days post termination. Other plans will accept retroactive terminations for up to the preceding three months, if the plan has not paid

[6] Claims Denials and Appeals in ACA Marketplace Plans in 2021 | KFF (Feb. 9, 2023) (last visited Jan. 31, 2024).
[7] How to appeal an insurance company decision | HealthCare.gov (last visited Jan. 20, 2024).
[8] 10 Factors that Could Trigger an Audit of Your Medical Records | LW Consulting, Inc. (lw-consult.com) (last visited Jan. 30, 2024).
[9] Microsoft Word - Brevard_Indian River County Auth List_4-16 (hf.org) (last visited Jan. 30, 2024).

any claims for the insurer or HMO during that period. If claims have been paid within the previous 60 days, the coverage termination date may be established as of the end of the month in which services were rendered.

When a provider is notified of a retroactive termination, the provider may have already verified that the insured or subscriber was covered, rendered services in reliance and expectation of payment, and even received payment. Retroactive terminations often result in the provider or the consumer bearing the loss, despite the verified eligibility.

Federal Subsidized Individual Policies or Contracts and Grace Periods

The federal Patient Protection and Affordable Care Act (PPACA)[10] guarantees access to coverage and mandates certain essential health benefits, including pediatric dental coverage,[11] and other requirements. To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans (QHPs) on a state or federal exchange.[12] For plan year 2024, Florida enrollees accounted for about 20 percent (4,211,902 individuals) of the 21.2 million total individuals) enrolled through the state and federal exchanges.[13] For plan year 2023, approximately 3,108,149 Floridians enrolled, and about 97 percent received tax credits.[14]

Under PPACA, insurers and HMOs must provide a grace period[15] of at least three consecutive months[16] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid 1-month's premium. During the grace period, the insurer or HMO must pay all appropriate claims for services provided during the first month of the grace period. For the second and third months, an insurer may pend claims. Insurers or HMOs must notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer or HMO may deny the payment of claims incurred during the second and third months.[17]

If the insured or subscriber resolves all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and

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[10] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010.

[11] Dental coverage is an essential health benefit for children under age 18, and must be available for a child either as part of a health plan or as a separate dental plan. https://www.healthcare.gov/coverage/dental-coverage/ (last visited Jan. 30, 2024).

[12] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line for their family size. https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last viewed Feb. 24, 2024).

[13] Centers for Medicare and Medicaid Services, Marketplace 2024 Open Enrollment Period Report: Final National Snapshot (Jan. 24, 2024) Marketplace 2024 Open Enrollment Period Report: Final National Snapshot | CMS

[14] Centers for Medicare and Medicaid Services, Effectuated Enrollment: Early 2023 Snapshot and Full Year 2022 Average (March 2023) https://www.cms.gov/files/document/early-2023-and-full-year-2022-effectuated-enrollment-report.pdf (last visited Feb. 1, 2024).

[15] Example of grace period: Premium is not paid in May. Premium payments are made in June and July. Grace period would end July 31. Coverage would be cancelled retroactively to the last day of May. See https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/ (last visited Jan. 30, 2024).

[16] 45 C.F.R. s. 155.430.

[17] 45 C.F.R. s. 156.270.

third month would be denied. If coverage is terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any payment for claims made during the first month of the grace period. At the end of grace period, the provider may seek payment for the medical services the insurer denied for months two and three. According to a 2014 survey, 48 percent of the providers not participating with any PPACA exchange products cited concerns about assuming financial liability during the grace period as a reason for their decision.[18]

According to the OIR, there are plans on the Exchange that offer dental coverage for either an adult or child or both embedded in a policy or contract. There are plans on the Exchange that offer standalone dental coverage, and such coverage may vary by county. Typically, insurers and HMOs submit rate filings for policies or contracts in June and finalize such filings by August for the following calendar plan year.[19]

Grace Periods for Policies or Contracts without a Federal Subsidy

The federal regulation governing grace periods for federally subsidized policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange QHP or who are enrolled in an exchange QHP and do not receive a subsidy. The grace period for these individual policies or contracts remain at the length required under Florida law,[20] 14 which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force. The policy is in force during the grace period, thus the insurer or HMO must affirm that an individual is insured, even when the payment is late and remains unpaid during the grace period. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may retroactively deny any claims incurred during the grace period.

Oversight of HMO Contracts with Dentists

A contract between an HMO and a dentist licensed under chapter 466, F.S., for the provision of services to a subscriber of the HMO may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract.[21] The term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods,

[18] Tracy Gnadinger, Health Policy Brief: The Ninety-Day Grace Period, (Oct. 16, 2014) *available at* http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last viewed Jan. 31, 2024).
[19] Correspondence with K. Jacobs, Deputy Chief of Staff, OIR (Feb. 2, 2024). On file with Senate Banking and Insurance Committee.
[20] Sections 627.608 and 641.31(15), F.S. The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due. [Section 627.6645, F.S.].
[21] Section 641.315(11), F.S.

annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.[22]

Oversight of Prepaid Limited Health Services Organizations (PLHSOs) Contracts with Dentists

Pursuant to Part I of ch. 636, F.S., the OIR regulates PLHSOs. A PLHSO is any entity which, in return for a prepayment, provides limited health services to enrollees through an exclusive panel of providers.[23] Prepaid limited health service organization does not include:

- An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service;
- A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, an HMO, a health insurer, or a self-insurance plan; or
- Any person who is licensed pursuant to part II of ch. 636, F.S., as a discount plan organization.[24]

A PLHSO provides the following limited health services:

- Ambulance services;
- Dental care services;
- Vision care services;
- Mental health services;
- Substance abuse services;
- Chiropractic services;
- Podiatric care services; and pharmaceutical services.[25]

The PLHSO arrangements or contracts with providers PLHSOs are governed by s. 636.035, F.S. A contract between a PLHSO and a dentist licensed under chapter 466, F.S., for the provision of services to a subscriber of the PHLSO, may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the PLHSO unless such services are covered services under the applicable contract. As used in subsection (7), the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Prompt Payment of Health Insurer and HMO Claims

The Florida Insurance Code prescribes rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in

[22] *Id.*
[23] Section 636.003(7), F.S.
[24] *Id.*
[25] Section 636.003(5), F.S.

accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[26] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services, through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Oversight of the Practice of Dentistry in Florida

The Board of Dentistry (BOD) within the Department of Health is the state's regulatory board for the practice of dentistry, dental hygienists, and dental assistants under the Dental Practice Act.[27] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[28]

Credit Virtual Card Payments and Fees Imposed on Dentists[29]

According to the American Dental Association (ADA), dental insurance companies and third party administrators may pay dental offices with a credit or debit card instead of a traditional check. Many companies provide virtual credit card services and offer a virtual stored-value debit card program designed specifically for claims payments. Generally, the cards are delivered to the dental office either by fax or email. Then, the dental office processes the payment by entering the card number, security code, expiration date and amount.

The ADA notes that companies may market the quicker reimbursement as a benefit for dentists to use the credit/virtual card; however, dentists may incur a higher processing fee for virtual cards than a traditional debit or credit card transaction. The ADA suggests that a dental office can request to opt out of using the card and instead receive a paper check as payment for services rendered. The ADA suggests that a dental office may need to contact the card issuing company and not necessarily the dental plan to resolve this payment issue.

A representative of the Florida Dental Association noted that 21 states have enacted legislation to address credit or virtual card payments.[30]

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[26] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organizations, and specified contracts.
[27] Section 466.004, F.S.
[28] Section 466.003(3), F.S.
[29] Credit Virtual Card Payment (ada.org) (2021) (last visited Jan. 31, 2024).
[30] Correspondence from Joe Ann Hart, (Feb. 1, 2024) on file with Senate Banking and Insurance Committee. See also ADA Dental Insurance Reform Virtual Credit Cards Dental Insurance Reform, Virtual Credit Cards, and State Law. (2021) (last visited Jan. 31, 2024).

III. Effect of Proposed Changes:

Credit Card Payments and Fees (Sections 1, 3, and 5)
The bill prohibits a health insurer, HMO or PLHSO from specifying credit card payment as the only acceptable method for payments to the dentist. The bill requires a health insurer, HMO or PLHSO to provide a written notice to the dentist at least 10 days before the payment of a claim to a dentist through electronic funds transfer, including but not limited to, virtual credit card payments the following information:

- The fee, if any, associated with the electronic funds transfer.
- The available methods of payment of claims by the health insurer, HMO or PLHSO including instructions to the dentist on how to select an alternative payment.

Further, the bill:

- Prohibits a health insurer, HMO or PLHSO that pays a claim to a dentist through an Automated Clearing House (ACH) transfer to charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.
- Provides that these provisions may not be waived, voided, or nullified by contract.
- Authorizes the OIR to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S.
- Authorizes the Financial Services Commission to adopt rules.

Limitations on Insurers, HMOs, or PLHSOs Denying Payment of Claims for Procedures Included in Prior Authorizations (Sections 1, 4, and 5)

The bill prohibits an insurer, HMO or PLHSO from denying any claim subsequently submitted by a dentist for procedures that were included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

- Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.
- The documentation provided by the person submitting the claim fails to support the claim as originally authorized.
- Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.
- Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.
- The denial of the claim was due to one of the following:
  - Another payor is responsible for payment.
  - The dentist has already been paid for the procedures identified in the claim.
  - The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist, patient, or other person not related to the insurer.

- The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

Further, the bill provides that these provisions may not be waived, voided, or nullified by contract. The bill authorizes the OIR to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S., and authorizes the Financial Services Commission to adopt rules.

Provider Contracts and Covered Services (Sections 2, 4, and 5)

The bill revises the definition of covered services to mean dental care services for which a reimbursement is available under the contract or agreement of the insurer, HMO or PLHSO, notwithstanding the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation. As a result, if an insured or subscriber reaches their benefit limits prior to the end of plan year, the dentist is not required to bill the insured or subscriber at the negotiated rate. The dentist may charge a higher rate.

Effective Date (Section 6)

Provides the bill is effective July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

To the extent that the bill applies to contracts and insurance policies entered into or renewed before the effective date of July 1, 2024, the bill could impair those contracts. Article I, Section 10 of the United States Constitution prohibits state legislatures from enacting laws impairing the obligation of contracts. The severity of the impairment is a key issue when evaluating whether a state law impairs a contract.[31] In Exxon Corp. v

[31] General Motors Corp. v. Romein, 503 U.S. 181 (1992).

Eagerton, 462 U.S. 176 (1983), the Supreme Court suggested it would uphold legislation that imposes a generally applicable rule of conduct designed to advance a broad societal interest that only incidentally disrupts existing contractual relationships.

Article I, section 10 of the Florida Constitution also prohibits the state from enacting laws impairing the obligation of contracts. While Florida courts have historically strictly applied this restriction, they have exempted laws when they find there is an overriding public necessity for the state to exercise its police powers.[32] This exception extends to laws that are reasonable and necessary to serve an important public purpose,[33] to include protecting the public's health, safety or welfare.[34] For a statute to offend the constitutional prohibition against impairment of contract, the statute must have the effect of changing substantive rights of the parties to an existing contract. Any retroactive application of a statute affecting substantive contractual rights would be constitutionally suspect.[35] Historically, both the state and federal courts have attempted to find a rational and defensible compromise between individual rights and public welfare when laws are enacted that may impair existing contracts.[36] The balancing process focuses on whether "the nature and extent of the impairment is constitutionally tolerable in light of the importance of the state's objective, or whether it unreasonably intrudes into the parties' bargain to a degree greater than is necessary to achieve that objective."[37]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Dentists may experience savings in fees if they may opt out of the payment of claims by credit cards. Further, dentists may realize additional revenues if an insurer, HMO or PLHSO is limited in their ability to subsequently deny claims that they previously authorized. The impact on insurers, HMOs or PLHSOs is indeterminate.

Insureds or subscribers that have exhausted their dental policy limits prior to the end of the policy or contract period may not be able to obtain additional services at the negotiated rate if the dentist chooses to use a higher rate.

Federal regulations govern the grace period and payment of claims of individuals receiving federally subsidized products on the exchange. This bill would not apply to such claims.

[32] Park Benziger & Co. v. Southern Wine & Spirits, Inc., 391 So.2d 681 (Fla. 1980).
[33] Yellow Cab Co. v. Dade County, 412 So.2d 395 (Fla. 3rd DCA 1982), petition den. 424 So.2d 764 (Fla. 1982).
[34] 4 Khoury v Carvel Homes South, Inc., 403 So.2d 1043 (Fla. 1st DCA 1981), petition den. 412 So.2d 467 (Fla. 1981).
[35] 5 Tri-Properties, Inc. v. Moonspinner Condominium Association, Inc., 447 So.2d 965 (Fla. 1st DCA 1984).
[36] Pomponio v Claridge of Pompano Condominium, Inc., 378 So.2d 774 (Fla. 1979).
[37] *Id at 780.*

The provisions of the bill would not apply to ERISA (Federal Employee Retirement Income Security Act of 1974)[38]22 self-insured plans. ERISA preempts the regulation of such plans by the state.

C. Government Sector Impact:

The fiscal impact of the bill on State Group Insurance is unknown.

VI. Technical Deficiencies:

The effective date of the bill is July 1, 2024. Typically, health insurers and HMOs file rates with the OIR in June for the next calendar year and finalize the rates around August. The Division of State Group Insurance plan year is also on a calendar year basis.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 627.6131, 627.6474, 636.032, 636.035, and 641.315 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance Feb. 5, 2024:
The CS eliminates a provision in the bill that would authorize a health insurer, a prepaid limited health service organization or a health maintenance organization to charge a reasonable fee for other value-added services related to ACH transfers.

B. Amendments:

None.

[38] 29 U.S.C. 1001 *et seq*. (1974).

642356

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/08/2024	.	
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	.	

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

Senate Amendment (with title amendment)

Delete lines 90 - 307

and insert:

has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this

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subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient’s condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient’s plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

642356

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist, patient, or other person not related to the insurer.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 2. Subsection (2) of section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as

642356

deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Section 3. Section 636.032, Florida Statutes, is amended to read:

636.032 Acceptable payments.—

(1) Each prepaid limited health service organization may accept from government agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber may not specify credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) At least 10 days before a limited health service organization pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the prepaid limited health service organization shall notify the dentist in writing of all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the prepaid limited health service organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A prepaid limited health service organization that pays a claim to a dentist through Automatic Clearing House (ACH)

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transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

Section 4. Subsection (13) of section 636.035, Florida Statutes, is amended, and subsection (15) is added to that section, to read:

636.035 Provider arrangements.—

(13) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the prepaid limited health service organization may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other

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limitation.

(15)(a) A prepaid limited health service organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the dental service claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior

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authorization was based in whole or material part on erroneous information provided to the prepaid limited health service organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the prepaid limited health service organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 5. Subsection (11) of section 641.315, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this subsection, the term “covered

642356

services" means dental care services for which a reimbursement is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) At least 10 days before a health maintenance organization pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the health maintenance organization shall notify the dentist in writing of all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the health maintenance organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health maintenance organization that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

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

642356

And the title is amended as follows:

Delete lines 11 - 58

and insert:

providing construction; authorizing the Office of Insurance Regulation of the Financial Services Commission to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health insurer from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 627.6474, F.S.; revising the definition of the term "covered services"; amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; revising the definition of the term "covered services"; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior

642356

authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 641.315, F.S.; revising the definition of the term "covered service"; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring the health maintenance organization to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a health maintenance organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction;

By Senator Harrell

31-00708-24 2024892__

A bill to be entitled

An act relating to dental insurance claims; amending s. 627.6131, F.S.; prohibiting a contract between a health insurer and a dentist from containing certain restrictions on payment methods; requiring a health insurer to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a health insurer from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; authorizing a health insurer to charge reasonable fees for other value-added services related to the ACH transfer; providing construction; authorizing the Office of Insurance Regulation of the Financial Services Commission to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health insurer from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 627.6474, F.S.; revising the definition of the term "covered services"; amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a

31-00708-24 2024892__

prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; authorizing the prepaid limited health service organization to charge reasonable fees for other value-added services related to the ACH transfer; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; revising the definition of the term "covered services"; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 641.315, F.S.; revising the definition of the term "covered service"; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring the health maintenance organization to make certain notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a health maintenance organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; authorizing the health maintenance organization to charge reasonable fees for other value-added services related to the ACH transfer; providing construction;

authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health maintenance organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; providing an effective date.

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

Section 1. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not specify credit card payment as the only acceptable method for payments from the health insurer to the dentist.

(b) At least 10 days before a health insurer pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the health insurer shall notify the dentist in writing of all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health insurer that pays a claim to a dentist through

Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for other value-added services related to the ACH transfer, including, but not limited to, transaction management, data management, and portal services.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary,

based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist, patient, or other person not related to the insurer.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 2. Subsection (2) of section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Section 3. Section 636.032, Florida Statutes, is amended to read:

636.032 Acceptable payments.—

(1) Each prepaid limited health service organization may accept from government agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber may not specify credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) At least 10 days before a limited health service organization pays a claim to a dentist through electronic funds

transfer, including, but not limited to, virtual credit card payments, the prepaid limited health service organization shall notify the dentist in writing of all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the prepaid limited health service organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A prepaid limited health service organization that pays a claim to a dentist through Automatic Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A prepaid limited health service organization may charge reasonable fees for other value-added services related to the ACH transfer, including, but not limited to, transaction management, data management, and portal services.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

Section 4. Subsection (13) of section 636.035, Florida Statutes, is amended, and subsection (15) is added to that section, to read:

636.035 Provider arrangements.—

(13) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the prepaid limited health service organization may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(15)(a) A prepaid limited health service organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the

condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the dental service claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the prepaid limited health service organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the prepaid limited health service organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this

subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 5. Subsection (11) of section 641.315, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) At least 10 days before a health maintenance

organization pays a claim to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payments, the health maintenance organization shall notify the dentist in writing of all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the health maintenance organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health maintenance organization that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health maintenance organization may charge reasonable fees for other value-added services related to the ACH transfer, including, but not limited to, transaction management, data management, and portal services.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(14)(a) A health maintenance organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances

applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health maintenance organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the health

maintenance organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) The subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 6. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Health and Human Services, *Chair*
Environment and Natural Resources, *Vice Chair*
Appropriations
Appropriations Committee on Education
Education Postsecondary
Health Policy
Judiciary

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR GAYLE HARRELL
31st District

January 16, 2024

Senator Jim Boyd
418 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Boyd,

I respectfully request that SB 892 – Dental Insurance Claims be placed on the next available agenda for the Banking and Insurance Committee Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Senator Gayle Harrell
Senate District 31

Cc: James Knudson, Staff Director
Amaura Canty, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 414 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

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

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Feb. 6, 2024
Meeting Date

Banking & Insurance
Committee

SB 892
Bill Number or Topic

642356
Amendment Barcode (if applicable)

Name Joe Anne Hart

Phone 850.224.1089

Address 118 East Jefferson St
Street

Email jahart@floridadental.org

Tall, FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

Florida Dental Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2-6-24
Meeting Date

Banking & Insurance
Committee

SB892
Bill Number or Topic

Amendment Barcode (if applicable)

Name Joy Ryal

Phone 850-425-4000

Address 300 S Duval St, #410
Street

Email joy@meenanlawfirm.com

Tally 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Feb. 6, 2024
Meeting Date

Banking & Insurance
Committee

SB 892
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Bert Hughes

Phone 352 378 3323

Address 316 SW 16th Ave
Street

Email info@drberthughes.com

Gainesville FL 32601
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[X] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Dental Association

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Feb. 6, 2024
Meeting Date

Banking & Insurance
Committee

SB 892
Bill Number or Topic

Amendment Barcode (if applicable)

Name Joe Anne Hart

Phone 850.224.1089

Address 118 East Jefferson St.
Street

Email jahart@floridadental.org

Tall, Fl 32301
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[X] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Dental Association

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Committee

892
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kevin Comerer

Phone

Address
Street

Email

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

Assoc. of Dental Support Organizations

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 892
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/06/2024 adopted 1 Harrell					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
X		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
10	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 964
INTRODUCER:	Banking and Insurance Committee and Senator Calatayud
SUBJECT:	Coverage of Biomarker Testing
DATE:	February 8, 2024 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 964 requires Florida's Medicaid program and the Division of State Group Insurance program to provide coverage for biomarker testing for the diagnosis, treatment, management, and ongoing monitoring of disease or condition of an enrollee or insured, respectively to guide treatment decisions when the following conditions are met:

- Such testing provides clinical utility to the insured or subscriber; and
- The testing is demonstrated by medical and scientific evidence, including but not limited to specified criteria in the bill.

Biomarker testing is a method to look for genes, proteins, and other substances (biomarkers or tumor markers) that can provide information about cancer and other conditions. Biomarker testing is a component of precision medicine, also known as personalized medicine, which is an approach to medical care in which disease prevention, diagnosis, and treatment are tailored to the genes, proteins, and other substances that are unique to a patient. Such testing may significantly improve health outcomes and prolong patient survival, particularly for those with advanced forms of cancer.

The bill may have a significant operational and fiscal impact on the Medicaid Program. The impact on the Division of State Group Insurance is unknown.

The bill has an effective date of July 1, 2024.

II. Present Situation:

Biomarkers[1] and Tumor Markers[2]

A biomarker is a biological molecule found in blood, other body fluids, or tissues that is a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or condition. A biomarker is also called molecular marker and a signature molecule. Biomarker testing is a method to look for genes, proteins, and other substances (biomarkers or tumor markers) that can provide information about cancer and other conditions.

A tumor marker is anything present in or produced by cancer cells or other cells of the body in response to cancer or certain benign (noncancerous) conditions that provides information about a cancer, such as how aggressive it is, what kind of treatment it may respond to, or whether it is responding to treatment.

Tumor markers have traditionally been proteins or other substances that are made at higher amounts by cancer cells than normal cells. These can be found in the blood, urine, tumors, or other tissues or bodily fluids of some patients with cancer. Increasingly, however, genomic markers (such as tumor gene mutations, patterns of tumor gene expression, and nongenetic changes in tumor DNA) are being used as tumor markers. These markers are found both in tumors themselves and in tumor fragments shed into bodily fluids. Many different tumor markers have been characterized and are in clinical use.[3] Some are associated with only one type of cancer, whereas others are associated with multiple cancer types.

Application of Tumor Markers in Cancer Care[4]

Tumor markers that indicate whether someone is a candidate for a particular targeted therapy[5] are sometimes referred to as biomarkers for cancer treatment. Tumor markers can provide a wide variety of information that is important for cancer care, such as:

- Helping to diagnose cancer. However, having an elevated level of a tumor marker does not mean that someone has cancer. Noncancerous conditions can sometimes cause an increase in the level of a tumor marker. In addition, not everyone with a particular type of cancer will have a higher level of a tumor marker associated with that cancer. Therefore, measurements of tumor markers are usually combined with the results of other tests, such as biopsies or imaging, to diagnose cancer.
- The type of cancer.
- The stage of the cancer.

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[1] Biomarker Testing for Cancer Treatment - NCI (last visited Jan. 25, 2024).
[2] Tumor Markers - NCI (cancer.gov) (last visited Jan. 28, 2024).
[3] Tumor Marker Tests in Common Use - NCI (cancer.gov) (last visited Jan. 24, 2024).
[4] *Supra* at 2.
[5] This is a type of treatment that uses drugs or other substances to target specific molecules that cancer cells need to survive and spread. Targeted therapies work in different ways to treat cancer. Some stop cancer cells from growing by interrupting signals that cause them to grow and divide, stopping signals that help form blood vessels, delivering cell-killing substances to cancer cells, or starving cancer cells of hormones they need to grow. Other targeted therapies help the immune system kill cancer cells or directly cause cancer cell death. Most targeted therapies are either small-molecule drugs or monoclonal antibodies. Also called molecularly targeted therapy. *See* Definition of targeted therapy - NCI Dictionary of Cancer Terms - NCI (last visited Jan. 27, 2024).

- An estimate of prognosis.
- Determination of what treatment may be effective. Biomarkers are generally measured in samples of tumor tissue. However, tumors can shed cells or bits of biological material into blood, and these can be measured by tests called liquid biopsies.
- How well the treatment is working. Periodic measurements of a marker made while someone is undergoing treatment can indicate whether the tumor is responding to treatment.
- Whether cancer has returned. Measuring tumor markers periodically after treatment has ended may be used to check for recurrence.

Types of Tumor Marker Tests

A number of tumor marker tests are currently being used for a wide range of cancer types.[6] Many tumor marker tests are conducted by commercial and academic laboratories. Sometimes cancer centers use a tumor marker test developed within a single clinical laboratory to meet a specific medical need. All tumor markers are tested in laboratories that meet standards set by the Clinical Laboratory Improvement Amendments program.[7]

State Regulation of Insurance

Office of Insurance Regulation

In Florida, the Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[8] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[9] The agency regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority[10] from the OIR, an HMO must receive a Health Care Provider Certificate from the agency. As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[11]

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services, through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Florida's Medicaid Program

Administration of the Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social

[6] Tumor Marker Tests in Common Use - NCI (cancer.gov) (last visited Jan. 23, 2024).
[7] Clinical Laboratory Improvement Amendments (CLIA) | CDC (last visited Jan. 23, 2024).
[8] Section 20.121(3)(a)1., F.S.
[9] Section 641.21(1), F.S.
[10] Sections 624.401 and 641.49, F.S.
[11] Section 641.495, F.S.

Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the Centers for Medicare and Medicaid Services (CMS) and maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed by the Florida Legislature.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request a formal waiver of the requirements codified in the SSA. Federal waivers give states flexibility not afforded through their Medicaid state plan.

In Florida, most Medicaid recipients receive their services through a managed care plan (Plan) contracted with the Agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.

Mandatory Medicaid Coverage for Biomarker Testing

Section 409.905, F.S., relating to mandatory Medicaid services, provides that the Agency may make payments for delineated services, which are required of the state by Title XIX of the Social Security Act. Currently, Florida fee for service (FFS) Medicaid and SMMC cover biomarker testing under s. 409.905(7), F.S., as a mandatory service under the category of "Independent Laboratory Services." Florida Medicaid reimburses eligible providers for biomarker testing services in accordance with Rule 59G-4.190, F.A.C., the Laboratory Services and Coverage Policy, and Rule 59G-4.002, F.A.C., the Independent and Practitioner Laboratory Fee Schedules. An eligible recipient must be enrolled in the Florida Medicaid program on the date of service, and the services provided must be determined medically necessary, not duplicative of another service, and meet the criteria of the policy. When determining coverage or if it is appropriate to add a code to a FFS Medicaid fee schedule, the Agency considers clinical and practice guidelines as well as costs and maintaining budget neutrality.

The SMMC plans have the flexibility to cover services above and beyond the Agency's coverage policies, but they may not be more restrictive than Agency policy.

Medically Necessary or Medical Necessity.[12] Under Florida's Medicaid program, for a medical or allied care, goods, or services furnished or ordered to be considered medically necessary or a medical necessity, it must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

[12] Agency for Health Care Administration, Florida Medicaid, Definitions Policy (Aug. 2017) Definitions of commonly used terms that are applicable to all sections of Rule 59G, F.A.C., unless otherwise specified.

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
- Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

Federal and State Insurance Coverage for Biomarker Testing

In 2020 and 2022, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination[13] and local coverage determination[14] that increased access to comprehensive biomarker testing and next-generation sequencing for Medicare beneficiaries.[15] Since 2021, some states have enacted laws mandating coverage of testing, diagnosis, treatment, management, or monitoring of a medical condition, including the following states:

- Louisiana Senate Bill 84 requires broad health insurance coverage for genetic and molecular testing for cancer only.[16]
- Illinois House Bill 1779 requires state-regulated insurance and managed care plans to cover biomarker testing for the purposes of diagnosis, treatment, management, or monitoring of any medical condition.[17]
- Arizona House Bill 2144 requires health insurance coverage for biomarker testing for the purposes of diagnosis, treatment, management, or monitoring of any medical condition.[18]
- Rhode Island Senate Bill 2201 requires state-regulated individual and group health insurance plans to cover biomarker testing for the purposes of diagnosis, treatment, management, or monitoring of any medical condition.[19]

Recent Studies on the Cost of Biomarker Testing

A 2022 study found the addition of biomarker testing (liquid biopsy) for non-small cell lung cancer resulted in incremental cost savings of $3,065 per patient compared to tissue biopsy alone. Increased detection of actionable alterations, using liquid biopsy, was also associated with

[13] NCD - Next Generation Sequencing (NGS) (90.2) (cms.gov) (last visited Jan. 20, 2024).
[14] LCD - Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810) (cms.gov) (last visited Jan 20, 2024).
[15] State Legislation Requiring Coverage of Biomarker Testing Gains Momentum (accc-cancer.org) (Sep. 30, 2022) (last visited Jan. 24, 2024).
[16] LA SB84 | 2021 | Regular Session | LegiScan (last visited Jan. 24, 2024).
[17] IL HB1779 | 2021-2022 | 102nd General Assembly | LegiScan (last visited Jan. 24, 2024).
[18] AZ HB2144 | 2022 | Fifty-fifth Legislature 2nd Regular | LegiScan (last visited Jan. 24, 2024).
[19] RI S2201 | 2022 | Regular Session | LegiScan (last visited Jan. 24, 2024).

more patients being treated with targeted therapy. Major drivers of cost-effectiveness were drug acquisition costs and prevalence of actionable alterations.[20]

A 2018 study, found that biomarker testing for non-small cell lung cancer, instead of single-gene testing, decreased expected testing procedure related costs to the health plan payer by $24,651. First-line and maintenance treatment costs increased by $842,205, offset by a $385,000 decrease in second-line treatment and palliative care costs. Over 5 years, total budget impact was $432,554 ($0.0072 per member per month).[21]

III. Effect of Proposed Changes:

The bill creates the following definitions:

- "Biomarker" means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes, but is not limited to, molecular, histologic, radiographic, and physiologic characteristics but does not include an assessment of how a patient feels, functions, or survives.
- "Biomarker testing" means an analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes, but is not limited to, single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that the Centers for Medicare and Medicaid Services has either certified pursuant to the federal Clinical Laboratory Improvement Amendments (CLIA) or that has obtained a CLIA certificate of waiver by the United States Food and Drug Administration for the tests.
- "Clinical utility" means that the test result provides information used in the formulation of a treatment or in a monitoring strategy that impacts a patient's outcome and informs the clinical decision.
- "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

State Group Insurance Program

Section 1 amends s. 110.12303, F.S., relating to the State Group Insurance program (program) to mandate coverage of biomarker testing for policies issued on or after January 1, 2025. This

[20] Ezeife DA, Spackman E, Juergens RA, Laskin JJ, Agulnik JS, Hao D, Laurie SA, Law JH, Le LW, Kiedrowski LA, Melosky B, Shepherd FA, Cohen V, Wheatley-Price P, Vandermeer R, Li JJ, Fernandes R, Shokoohi A, Lanman RB, Leighl NB. The economic value of liquid biopsy for genomic profiling in advanced non-small cell lung cancer. Ther Adv Med Oncol. 2022 Jul 26;14:17588359221112696. doi: 10.1177/17588359221112696. PMID: 35923926; PMCID: PMC9340413. The economic value of liquid biopsy for genomic profiling in advanced non-small cell lung cancer - PubMed (nih.gov) (last visited Jan. 27, 2024).

[21] Yu TM, Morrison C, Gold EJ, Tradonsky A, Arnold RJG. Budget Impact of Next-Generation Sequencing for Molecular Assessment of Advanced Non-Small Cell Lung Cancer. Value Health. 2018 Nov;21(11):1278-1285. doi: 10.1016/j.jval.2018.04.1372. Epub 2018 Jun 8. PMID: 30442274. https://pubmed.ncbi.nlm.nih.gov/30442274/ (last visited Jan. 28, 2024).

coverage would include the diagnosis, treatment, management, or ongoing monitoring of an insured's disease or condition to guide treatment decisions when such testing provides clinical utility to the insured and is demonstrated by medical and specified medical and scientific evidence, including but not limited to, any of the following:

- Labeled indications for a test approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.
- Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.
- Nationally recognized clinical practice guidelines.

The program is required to outline a process for insureds and providers to access a process to request an authorization for biomarker testing.

The biomarker testing services may not be construed to require coverage of biomarker testing for screening purposes.

Medicaid Program

Optional Medicaid Services

Section 2 amends s. 409.906, F.S., relating to optional Medicaid services. Subject to specific appropriations, this section currently authorizes the Agency for Health Care Administration (Agency) to make payments for services which are considered optional under federal Medicaid law. However, such services must be medically necessary and in accordance with state and federal law.

The bill amends this section by providing that the Agency may pay for biomarker testing for diagnosis, treatment, management, or ongoing monitoring of a recipient's disease or condition to guide treatment decisions when such testing provides clinical utility to the recipient and is demonstrated by medical and specified medical and scientific evidence, including but not limited to, any of the following:

- Labeled indications for a test approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.
- Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.
- Nationally recognized clinical practice guidelines.

The Agency is also required to outline a process for enrollees and providers to access a process to request an authorization for biomarker testing.

The biomarker testing services may not be construed to require coverage of biomarker testing for screening purposes.

Medicaid Managed Care Plans

Section 3 creates s. 409.9745, F.S., to require managed care plans to provide coverage for biomarker testing for enrollees, as authorized under s. 409.906, F.S., at the same scope, duration, and frequency as the Medicaid program provides for other medically necessary treatments.

Managed care plans are required to outline a process for enrollees and providers to access a process for requesting authorization of biomarker testing.

The bill provides that this provision may not be construed to require coverage of biomarker testing for screening purposes.

Effective Date

Section 4 provides that the bill has an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The bill requires the Medicaid fee for service and the Medicaid managed care plans and the State Group Insurance program to cover biomarker testing for diagnosis, treatment, management, and ongoing monitoring of a disease or condition of an enrollee to guide treatment decisions when such testing provides clinical utility to the recipient and must be demonstrated by medical and scientific evidence, *including but not limited* to:

- Labeled indications for a test approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.
- Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.
- *Nationally recognized clinical practice guidelines*.

Use of the term "including but not limited to" indicates that the bill does not provide an all-inclusive list for medical and scientific evidence, and it is unclear who would determine the credibility or admissibility of it. Further, the term, "nationally recognized

clinical practice guidelines," does not provide specific named guidelines or examples. The bill provides no rulemaking authority, guidance or standards for the Agency for Health Care Administration or the State Group Insurance program to use for establishing this additional criteria. Thus, this additional, unspecified medical and scientific evidence or guidelines for determining coverage may be an unlawful delegation of legislative authority.

The Legislature may not delegate its constitutional duties to another branch of government.[22] While the Legislature must make fundamental policy decisions, it may delegate the task of implementing that policy to executive agencies with "some minimal standards and guidelines ascertainable by reference to the enactment establishing the program."[23] Moreover, the Legislature can permit "administration of legislative policy by an agency with the expertise and flexibility to deal with complex and fluid conditions."[24]

Florida courts have found an unlawful delegation of legislative authority in the following instances:

- Where the Legislature allowed the Department of State to "in its discretion allow such a candidate to withdraw…";[25] and
- Where the Legislature created a criminal penalty for escape from certain classifications of juvenile detention facilities, but delegated the classification (or determination whether to classify at all) to an agency.[26]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate. The mandated coverage is anticipated to reduce the overall costs of care of an enrollee, insured, or subscriber as a result of the use of a more targeted, optimal treatment protocol.

C. Government Sector Impact:

Florida's Medicaid Program[27]

The bill would limit the Agency's ability to determine coverage of biomarker testing using the current Agency's established process. The bill could have both a significant

[22] See FLA. CONST. art. II, s. 3.
[23] Askew v. Cross Key Waterways, 372 So.2d 913, 925 (Fla. 1978).
[24] Microtel, Inc. v. Fla. Public Serv. Comm'n., 464 So.2d 1189, 1191 (Fla. 1991).
[25] Fla. Dep't. of State, Div. of Elections v. Martin, 916 So.2d 763 (Fla. 2005).
[26] D.P. v. State, 597 So.2d 952 (Fla. 1st DCA, 1992)(disapproved on other grounds).
[27] Correspondence from Patrick Steele, Legislative Affairs Director, Agency for Health Care Administration (Feb. 1, 2024). On file with Senate Banking and Insurance Committee staff.

operational and fiscal impact on the Medicaid Program as it would require the Agency to cover all codes that meet the clinical criteria defined by the bill.

CS/HB 885 (companion to SB 964) mandates specific criteria by which biomarker testing must be evaluated for coverage by Florida Medicaid. Currently, the Agency does not define "specific nationally recognized clinical practice guidelines" that are referenced in CS/HB 885 and SB 964 in rule for determining coverage. Covered services must be medically necessary as defined by Rule 59G-1.010, F.A.C., not duplicate another service, and meet the criteria in the service specific coverage policy. When determining coverage or if it is appropriate to add a code to a FFS Medicaid fee schedule, the Agency considers clinical and practice guidelines as well as costs and maintaining budget neutrality.

Typically, the Agency does not cover every code designated by the American Medical Association for a covered service. For example, the Agency covers integumentary and wound care supplies under s. 409.906 F.S., Optional Medicaid services. There are a total of 87 skin substitute procedure codes listed in the AMA CPT codebook. Of these, Florida Medicaid covers a total of 26 CPT codes.

There are numerous biomarker tests that are Propriety Laboratory Analyses (PLA) Current Procedural Terminology (CPT) codes. A PLA code is a code set approved by the American Medical Association (AMA) CPT Editorial Panel. These codes are corresponding descriptors for labs or manufactures that want to identify their proprietary test more specifically. Florida Medicaid currently covers 46 non-PLA biomarker CPT codes under the Laboratory Services Fee Schedule that are listed on the CMS List for Billing and Coding: Biomarkers for Oncology. Florida Medicaid does not typically include PLA codes on FFS fee schedules when determining coverage based on the Agency's current coverage determination process.

Currently, managed care plans have the flexibility to cover services above and beyond the Agency's fee schedules and coverage policies, as well as reimburse providers mutually agreed upon rates. Plans may not be more restrictive in coverage than the Agency and promulgated rule, as detailed in their contract.

As currently written, the bill requires the Agency to cover every biomarker test when the medical and scientific evidence, as outlined in the bill, indicates clinical utility to the recipient. This requirement will have a significant fiscal impact to the Medicaid program which is indeterminate and on-going as the number of PLA and non-PLA codes that could meet this criteria is unknown. The impact will be ongoing as the bill will require the Agency to cover a biomarker test every time a new test meets the criteria outlined in the bill.

State Group Insurance

The fiscal impact of the mandated coverage on the State Group Insurance is indeterminate. It is unclear what particular biomarker tests are currently covered and the criteria that is used to determine coverage of such testing.

VI. Technical Deficiencies:

The additional coverage mandates and criteria for coverage created in ss. 409.906 and 409.9745, F.S. appear to conflict with current coverage requirements of s. 409.905, F.S. Currently, s. 409.905, F.S., relating to the federal mandatory services, requires Florida's fee for service and SMMC to provide coverage for biomarker testing, subject to medical necessity and other requirements. However, the bill requires Medicaid to provide coverage for biomarker testing under the optional services required by the state but subject to an appropriation, pursuant to s. 409.906, F.S. This would apply to fee for service, as well as managed care plans. Like mandatory federal services, optional services under the Medicaid program are subject to medical necessity and other requirements. However, the bill requires coverage of biomarker testing when the testing provides *clinical utility*, which appears to be a different standard than medical necessity.

The bill provides that the medical and scientific evidence that may be used to determine if biomarker testing provides clinical utility "includes, but is not limited to" certain specified items. The use of the phrase "includes, but is not limited to" results in the bill being unclear what the additional medical and scientific evidence would be that would require the coverage of a biomarker test.

VII. Related Issues:

The bill takes effect on July 1, 2024. However, the Medicaid managed care program rates are set on a plan year beginning October 1.

VIII. Statutes Affected:

This bill substantially amends sections 110.12303 and 409.906 of the Florida Statutes.
This bill creates section 409.9745 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 6, 2024:
The CS excludes commercial policies and contracts from the coverage mandate. Such coverage is mandated for the Medicaid fee for service program and the managed care plans and State Group Insurance.

B. Amendments:

None.

237278

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/08/2024	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (5) is added to section 110.12303, Florida Statutes, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(5)(a) As used in this subsection, the term:

1. "Biomarker" means a defined characteristic that is

237278

measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes, but is not limited to, molecular, histologic, radiographic, or physiologic characteristics but does not include an assessment of how a patient feels, functions, or survives.

2. "Biomarker testing" means an analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes, but is not limited to, single analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that is certified pursuant to the federal Clinical Laboratory Improvement Amendment (CLIA) or that has obtained a CLIA Certificate of Waiver by the United States Food and Drug Administration for the tests.

3. "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(b) For state group health insurance plan policies issued on or after January 1, 2025, the department shall provide coverage of biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions if medical and scientific evidence indicates that the biomarker testing provides clinical utility to the enrollee. Such medical and scientific evidence includes, but is not limited to:

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1. A labeled indication for a test approved or cleared by the United States Food and Drug Administration;

2. An indicated test for a drug approved by the United States Food and Drug Administration;

3. A national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by the Medicare Administrative Contractor; or

4. A nationally recognized clinical practice guideline. As used in this subparagraph, the term "nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Guidelines developed by such organizations or societies establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

(c) Each state group health insurance plan shall provide enrollees and participating providers with a clear and convenient process to request authorization for biomarker testing. Such process must be made readily accessible online to all enrollees and participating providers.

(d) This subsection does not require coverage of biomarker testing for screening purposes.

Section 2. Subsection (29) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which

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are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(29) BIOMARKER TESTING SERVICES.—

(a) As used in this subsection, the term:

1. "Biomarker" means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes, but is not limited to, molecular, histologic, radiographic, or physiologic characteristics but does not include an assessment of how a patient feels, functions, or

survives.

2. "Biomarker testing" means an analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes, but is not limited to, single analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that is certified pursuant to the federal Clinical Laboratory Improvement Amendment (CLIA) or that has obtained a CLIA Certificate of Waiver by the United States Food and Drug Administration for the tests.

3. "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(b) The agency may pay for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a recipient's disease or condition to guide treatment decisions if medical and scientific evidence indicates that the biomarker testing provides clinical utility to the recipient. Such medical and scientific evidence includes, but is not limited to:

1. A labeled indication for a test approved or cleared by the Unites States Food and Drug Administration;

2. An indicated test for a drug approved by the United States Food and Drug Administration;

3. A national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by the Medicare Administrative Contractor; or

4. A nationally recognized clinical practice guideline. As used in this subparagraph, the term "nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Guidelines developed by such organizations or societies establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

(c) Recipients and participating providers must be provided access to a clear and convenient process to request authorization for biomarker testing as provided under this subsection. Such process must be made readily accessible online to all recipients and participating providers.

(d) This subsection does not require coverage of biomarker testing for screening purposes.

(e) The agency may seek federal approval necessary to implement this subsection.

Section 3. Section 409.9745, Florida Statutes, is created to read:

409.9745 Managed care plan biomarker testing.—

(1) A managed care plan must provide coverage for biomarker testing for recipients, as authorized under s. 409.906, at the same scope, duration, and frequency as the Medicaid program provides for other medically necessary treatments.

(2) The managed care plan shall provide recipients and health care providers with access to a clear and convenient

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process to request authorization for biomarker testing as provided under this section. Such process must be made readily accessible on the managed care plan's website.

(3) This section does not require coverage of biomarker testing for screening purposes.

Section 4. This act shall take effect July 1, 2024.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to coverage for biomarker testing; amending s. 110.12303, F.S.; defining terms; requiring the Department of Management Services to provide coverage of biomarker testing for specified purposes for state employees' state group health insurance plan policies issued on or after a specified date; specifying circumstances under which such coverage may be provided; requiring state group health insurance plans to provide enrollees and participating providers with a clear and convenient process for authorization requests for biomarker testing; requiring that such process be readily accessible online; providing construction; amending s. 409.906, F.S.; defining terms; authorizing the Agency for Health Care Administration to pay for biomarker testing under the Medicaid program for specified purposes, subject to specific appropriations; specifying circumstances

under which such payments may be made; requiring that Medicaid recipients and participating providers be provided a clear and convenient process for authorization requests for biomarker testing; requiring that such process be readily accessible online; providing construction; authorizing the agency to seek federal approval for biomarker testing payments; creating s. 409.9745, F.S.; requiring managed care plans under contract with the agency in the Medicaid program to provide coverage for biomarker testing for Medicaid recipients in a certain manner; requiring managed care plans to provide Medicaid recipients and health care providers with a clear and convenient process for authorization requests for biomarker testing; requiring that such process be readily accessible on the managed care plan’s website; providing construction; providing an effective date.

By Senator Calatayud

38-00845-24 2024964__

A bill to be entitled

An act relating to coverage of biomarker testing; amending s. 409.905, F.S.; defining terms; requiring the Agency for Health Care Administration to provide specified coverage of biomarker testing under the Medicaid program; requiring managed care plans under contract with the agency to provide coverage of biomarker testing in a specified manner; requiring the agency to provide a clear, readily accessible, and convenient process for Medicaid recipients and providers to request an exception to the coverage; requiring that such process be made available in an online format on the agency's website; providing construction; creating ss. 627.64055 and 641.31708, F.S.; defining terms; requiring that certain health insurance policies and health maintenance contracts, respectively, provide specified coverage of biomarker testing; requiring that such coverage be provided in a manner that limits disruption in care; requiring insurers and health maintenance organizations, respectively, to provide a clear, readily accessible, and convenient process for covered individuals and ordering or prescribing practitioners to request an exception to the coverage; requiring that such process be made available on the insurers' and health maintenance organizations' respective websites; providing construction; providing an effective date.

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

38-00845-24 2024964__

Section 1. Subsection (13) is added to section 409.905, Florida Statutes, to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(13) BIOMARKER TESTING SERVICES.—

(a) As used in this subsection, the term:

1. "Biomarker" means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes molecular, histologic, radiographic, and physiologic characteristics but does not include an assessment of how a patient feels, functions, or survives.

2. "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a

biomarker. The term includes, but is not limited to, single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that the Centers for Medicare and Medicaid Services has either certified or granted a waiver under the federal Clinical Laboratory Improvement Amendments of 1988.

3. "Clinical utility" means that the test result provides information used in the formulation of a treatment or in a monitoring strategy that impacts a patient's outcome and informs the clinical decision.

4. "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

(b) The agency shall pay for biomarker testing for diagnosis, treatment, management, and ongoing monitoring of a recipient's disease or condition to guide treatment decisions when such testing provides clinical utility to the recipient and is demonstrated by medical and scientific evidence, including, but not limited to, any of the following:

1. Labeled indications for a test approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.

2. Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

3. Nationally recognized clinical practice guidelines.

(c) Managed care plans under contract with the agency to deliver services to recipients shall provide biomarker testing at the same scope, duration, and frequency as the Medicaid program otherwise provides to enrollees.

(d) The agency shall provide a clear, readily accessible, and convenient process for Medicaid recipients and providers to request an exception to a coverage policy under the Medicaid program or of managed care plans under contract with the agency to provide services to enrollees. Such process must be made available in an online format on the agency's website.

(e) This subsection may not be construed to require coverage of biomarker testing for screening purposes.

Section 2. Section 627.64055, Florida Statutes, is created to read:

627.64055 Coverage of biomarker testing.—

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

(a) "Biomarker" means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes molecular, histologic, radiographic, and physiologic characteristics but does not include an assessment of how a patient feels, functions, or survives.

(b) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a

biomarker. The term includes, but is not limited to, single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that the Centers for Medicare and Medicaid Services has either certified or granted a waiver under the federal Clinical Laboratory Improvement Amendments of 1988.

(c) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that impacts a patient's outcome and informs the clinical decision.

(d) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

(2) A health insurance policy issued, amended, delivered, or renewed in this state on or after January 1, 2025, must provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, and ongoing monitoring of an insured's disease or condition to guide treatment decisions when the testing provides clinical utility to the patient as demonstrated by medical and scientific evidence, including, but not limited to, any of the following:

(a) Labeled indications for a test approved or cleared by

the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.

(b) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(c) Nationally recognized clinical practice guidelines.

(3) Coverage of biomarker testing must be provided in a manner that limits disruptions in care, including the taking of multiple biopsies or biospecimen samples.

(4) The insurer shall provide a clear, readily accessible, and convenient process for insureds and ordering or prescribing practitioners to request an exception to coverage of biomarker testing in an insurance policy. Such process must be made available in an online format on the insurer's website.

(5) This section may not be construed to require coverage of biomarker testing for screening purposes.

Section 3. Section 641.31708, Florida Statutes, is created to read:

641.31708 Coverage of biomarker testing.—

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

(a) "Biomarker" means a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions. The term includes molecular, histologic, radiographic, and physiologic characteristics but does not include an assessment of how a patient feels, functions, or survives.

(b) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a

biomarker. The term includes, but is not limited to, single-analyte tests, multiplex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a participating in-network laboratory facility that the Centers for Medicare and Medicaid Services has either certified or granted a waiver under the federal Clinical Laboratory Improvement Amendments of 1988.

(c) "Clinical utility" means that the test result provides information used in the formulation of a treatment or in a monitoring strategy that impacts a patient's outcome and informs the clinical decision.

(d) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and with a conflict-of-interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

(2) A health maintenance contract issued, amended, delivered, or renewed in this state on or after January 1, 2025, must provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, and ongoing monitoring of a subscriber's disease or condition to guide treatment decisions when the testing provides clinical utility to the patient as demonstrated by medical and scientific evidence, including, but not limited to, any of the following:

(a) Labeled indications for a test approved or cleared by

the United States Food and Drug Administration (FDA) or indicated tests for an FDA-approved drug.

(b) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(c) Nationally recognized clinical practice guidelines.

(3) Coverage of biomarker testing must be provided in a manner that limits disruptions in care, including the taking of multiple biopsies or biospecimen samples.

(4) The health maintenance organization shall provide a clear, readily accessible, and convenient process for subscribers and ordering or prescribing practitioners to request an exception to coverage of biomarker testing in a health maintenance contract. Such process must be made available in an online format on the health maintenance organization's website.

(5) This section may not be construed to require coverage of biomarker testing for screening purposes.

Section 4. This act shall take effect July 1, 2024.

2/6
Meeting Date

Banking & Insurance
Committee

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

964
Bill Number or Topic

237278
Amendment Barcode (if applicable)

Name Alex Anderson

Phone 904 502 2506

Address 325 John Knox C-128
Street

Email AJAnderson@alz.org

TLH — FL — 32303
City — *State* — *Zip*

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Alzheimer's Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/6/24
Meeting Date

B & I
Committee

964
Bill Number or Topic

Amendment Barcode (if applicable)

Name Susan Harbin

Phone 770-546-8845

Address
Street

Email Susan.harbin@cancer.org

City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: American Cancer Society Cancer Action Network

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

Feb 6, 24
Meeting Date

964
Bill Number or Topic

Insurance & Banking
Committee

Amendment Barcode (if applicable)

Name Toni Large

Phone (850) 556-1461

Address 1100 Brookwood PR
Street

Email toni@largestrategies.com

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

Florida Society of Rheumatology

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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02/06/24
Meeting Date

Banking and Insurance
Committee

SB 964
Bill Number or Topic

Amendment Barcode (if applicable)

Name Anna Grace Lewis

Phone (850) 205-9000

Address 119 S. Monroe St. Suite 200
Street

Email agl@mhdfirm.com

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
The American Lung Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Community Affairs, Chair
Appropriations Committee on Education
Education Pre-K 12
Fiscal Policy
Health Policy
Select Committee on Resiliency

SENATOR Alexis Calatayud
38th District

January 5, 2024

Honorable Senator Jim Boyd
Chair - Committee Banking and Insurance
Honorable Chair Boyd,

I respectfully request that **SB-964 Coverage of Biomarker Testing** be placed on the next committee agenda.

The bill requires the Agency for Health Care Administration to provide specified coverage of biomarker testing under the Medicaid program; requiring managed care plans under contract with the agency to provide coverage of biomarker testing in a specified manner; requiring that certain health insurance policies and health maintenance contracts, respectively, provide specified coverage of biomarker testing; requiring that such coverage be provided in a manner that limits disruption in care.

Sincerely,

Alexis M. Calatayud

Senator Alexis M. Calatayud
Florida Senate, District 38

CC: James Knudson, Staff Director
Amaura Canty, Committee Administrative Assistant

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 964
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/06/2024 1 adopted Calatayud					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
X		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1064
INTRODUCER:	Banking and Insurance Committee and Senator Powell
SUBJECT:	Wills and Estates
DATE:	February 8, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collazo	Cibula	JU	**Favorable**
2.	Thomas	Knudson	BI	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1064 provides and clarifies procedures to resolve probate disputes regarding property owned by spouses in this state but acquired while the spouses lived in one of the nine community property states.

In a community property state, property acquired during a marriage is presumed to be owned 50/50 by the spouses regardless of how it may be titled. Once the spouses move to this state, state law provides that community property generally retains its status as community property. In 1992, the Legislature adopted the Florida Uniform Disposition of Community Property Rights at Death Act, to provide guidance for preserving the rights of a surviving spouse in any such community property upon a spouse's death if probate is opened in this state.

Nothing in the Act requires a surviving spouse to make a probate creditor claim to preserve his or her community property rights. However, a recent court case held that probate creditor claim procedures apply to title disputes arising under the Act, including the statute of limitations period and the two-year statute of repose applicable to such claims.

To address these issues, the bill amends and repeals various provisions of the Act, and other related provisions of the Florida Probate Code, to:

- Clarify existing law by exempting title disputes arising under the Act from:
  - The term "claim" as defined in the Florida Probate Code.

  - The limitations and the two-year statute of repose applicable to probate creditor claims under the Florida Probate Code.
- Create a new dispute resolution mechanism and two-year statute of repose specifically designed for title disputes arising under the Act.
- Make targeted and narrowly-focused modifications to the Act and other related provisions of the Florida Probate Code to improve clarity and reduce the risk of unintended forfeitures of the property rights the Act is intended to preserve.

The bill also ensures the availability of necessary information about deceased individuals is contained in the land records maintained by the Clerks of the Circuit Courts so that proper heirs can be identified in the chain of title, thereby protecting the public interest of certainty in the ownership of real property.

The bill provides that except as otherwise expressly provided in the bill, the bill takes effect upon becoming a law.

II. Present Situation:

Community Property

The term "community property" refers to the legal theory, applicable in nine states, that most property owned by a married person is jointly owned with the spouse.[1] Most assets and debts acquired during the marriage are considered community property and are equally owned by both spouses, regardless of in whose name the item is titled.[2]

In community property states, if the couple divorces, each spouse is entitled to one-half of the community assets and debts, including:
- Earned income generated during the marriage.
- Items purchased by either spouse during the marriage.
- Retirement accounts that are created during marriage or the value of contributions made during marriage to pre-existing accounts.
- Bank accounts and investments accumulated during the marriage.
- Separate property that is transferred to joint accounts.
- Separate property transmuted to marital property, such as when one spouse uses their own savings to help buy a family car in both names.[3]

Florida is not a community property state, but a common law property state.[4] Like in most other common law property states, how an asset is titled generally dictates who owns the asset and

[1] The nine states that have community-property systems are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin. Also, a community-property regime is elective in Alaska. BLACK'S LAW DICTIONARY (11th ed. 2019).
[2] Forbes Advisor, *Community Property States in 2024*, Aug. 23, 2022, https://www.forbes.com/advisor/legal/divorce/community-property-states/ (last visited February 1, 2024).
[3] *Id.*
[4] *See* s. 61.075(8), F.S. (providing that "[t]itle to disputed assets shall vest only by the judgment of a court" and that this statute "does not require the joinder of spouses in the conveyance, transfer, or hypothecation of a spouse's individual property; affect the laws of descent and distribution; *or establish community property in this state*" (emphasis added)); *see*

who has the ability to convey it during life or death.[5] For example, in the context of dissolution of marriage proceedings, while state law provides that equal or 50/50 shares may be the proper starting point in making an equitable distribution of marital assets, the distribution need not be equal.[6]

Florida Uniform Disposition of Community Property Rights at Death Act

Although Florida is not a community property state, many residents in the state come from community property states. Florida is the first choice for relocating retirees in the U.S.,[7] the largest recipient of domestic state-to-state migration within the U.S.,[8] and the largest recipient of international migration to the U.S.[9] At least one court has recognized that the testamentary intentions of these new residents should be honored.[10]

Accordingly, the purpose of the Florida Uniform Disposition of Community Property Rights at Death Act (the Act), which the state enacted in 1992,[11] is to statutorily preserve the testamentary "rights of each spouse in property which was community property prior to change of domicile, as well as in property substituted therefor where the spouses have not indicated an intention to sever or alter their 'community' rights."' The Act "thus follows the typical pattern of community property which permits the deceased spouse to dispose of 'his half' of the community property, while confirming the title of the surviving spouse in 'her half.'"[12]

The Act's Provisions

The Act applies to the disposition at death of the following property acquired by a married person:

- Personal property, wherever located, which:

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also, e.g., Herrera v. Herrera, 673 So. 2d 143, 144 (Fla. 5th DCA 1996) (providing that "Florida is not a community property state").

[5] Joseph M. Percopo, *Understanding the New Florida Community Property Trust, Part I*, 96 FLA. BAR JOURNAL 4, at 16 (July/Aug. 2022), available at https://www.floridabar.org/the-florida-bar-journal/understanding-the-new-florida-community-property-trust-part-i/ (last visited February 1, 2024).

[6] *See* s. 61.075(1), F.S. (noting that "in distributing the marital assets and liabilities between the parties [to a dissolution of marriage proceeding], the court must begin with the premise that the distribution should be equal, unless there is a justification for an unequal distribution based on all relevant factors, including [the listed factors]"); *see also Herrera*, 673 So. 2d at 144 (explaining that application of the statutory factors in s. 61.075, F.S., may result in an unequal distribution).

[7] Andy Markowitz, AARP, *Top 5 States Where Retirees Are Moving*, Jan. 6, 2023, https://www.aarp.org/retirement/planning-for-retirement/info-2023/most-popular-relocation-states.html (last visited February 1, 2024).

[8] Net domestic migration for Florida from April 1, 2020 to July 1, 2023 is 818,762 individuals, which exceeds all other states. *See* Census.gov, *Annual and Cumulative Estimates of the Components of Resident Population Change for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2023 (NST-EST2023-COMP)*, 2023, https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html (last visited February 1, 2024).

[9] Net international migration for Florida from April 1, 2020 to July 1, 2023 is 349,370 individuals, which exceeds all other states. *See* Census.gov, *Annual and Cumulative Estimates of the Components of Resident Population Change for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2023 (NST-EST2023-COMP)*, 2023, https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html (last visited February 1, 2024).

[10] *Malleiro v. Mori*, 182 So. 3d 5, 10-11 (Fla. 3d DCA 2015).

[11] Chapter 92-200, s. 4, Laws of Fla., codifying ss. 732.216-732.228, F.S.

[12] *See* Uniform Disposition of Community Property Rights at Death Act (UDCPRDA), *Prefatory Note*, at 3, available at https://www.uniformlaws.org/viewdocument/act-1971 (last visited February 1, 2024). The Act, with some modifications, is based upon the Uniform Disposition of Community Property Rights at Death Act (UDCPRDA) promulgated in 1971.

- Was acquired as, or became and remained, community property under the laws of another jurisdiction;
- Was acquired with the rents, issues, or income of, or the proceeds from, or in exchange for, community property; or
- Is traceable to that community property.

- Real property, except real property held as tenants by the entirety, which is located in this state, and which:
  - Was acquired with the rents, issues, or income of, the proceeds from, or in exchange for, property acquired as, or which became and remained, community property under the laws of another jurisdiction; or
  - Is traceable to that community property.[13]

The Act provides that, upon the death of a married person:

- One-half of the property to which the Act applies is the property of the surviving spouse and *is not* subject to testamentary disposition by the decedent or distribution under the laws of succession in the state.
- One-half of the property is the property of the decedent and *is* subject to testamentary disposition or distribution under the laws of succession of the state.
- The decedent's one-half of the property is not in the elective estate.[14]

Additionally, the Act provides for:

- Rebuttable presumptions.[15]
- Perfection of title of the:
  - Personal representative or beneficiary.[16]
  - Surviving spouse.[17]
- Rights of a purchaser for value or lender.[18]
- Creditors' rights.[19]
- Acts of married persons with regard to severing or altering their interests in property subject to the Act.[20]
- Limitations on testamentary disposition.[21]

The Act also defines the term "homestead" for the purpose of its provisions[22] and concludes with a declaration that its provisions are to be so applied and construed as to effectuate their general purpose to make uniform the law with respect to the subject of the Act among those states that enact it.[23]

[13] Section 732.217, F.S.
[14] Section 732.219, F.S.
[15] Section 732.218, F.S.
[16] Section 732.221, F.S.
[17] Section 732.223, F.S.
[18] Section 732.222, F.S.
[19] Section 732.224, F.S.
[20] Section 732.225, F.S.
[21] Section 732.226, F.S.
[22] Section 732.227, F.S.
[23] Section 732.228, F.S.

Johnson v. Townsend

In 2018, the Fourth District Court of Appeal decided *Johnson v. Townsend*.[24] In that case, the court concluded that state probate creditor claim procedures apply to title disputes arising under the Act, which arguably resulted in the unintended forfeiture of the surviving spouse's property rights.[25] The court reasoned that the surviving spouse's attempt to confirm her pre-existing right to "her half" of property to which the Act applied was a form of probate creditor "claim," as that term was defined under state law,[26] and therefore subject to the limitations period and the two-year statute of repose[27] applicable to creditor claims.[28]

The Real Property, Probate & Trust Law Section of The Florida Bar has noted that nowhere within the text of the Act, or in any other provision of the Florida Probate Code,[29] is it stated that the state's probate creditor claim procedures apply to title disputes arising under the Act.[30] Nor does such application comport with the Act's existing statutory scheme, which explicitly states that one-half of the property to which the Act applies – regardless of who holds title – belongs to the surviving spouse.[31] Accordingly, the section has taken the position that the effectiveness of the Act is diminished by the uncertainties created by the *Johnson* court's ruling.[32]

Recordation of Probate Records

State law[33] requires the Clerks of the Circuit Courts to record certain specified documents in the Official Records. They include:

- Wills and codicils admitted to probate.
- Orders revoking the probate of any wills and codicils.
- Letters of administration.
- Orders affecting or describing real property.
- Final orders.
- Orders of final discharge.
- Orders of guardianship.[34]

No other petitions, pleadings, papers, or other orders relating to probate matters may be recorded except on the written direction of the court.[35]

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[24] 259 So. 3d 851 (Fla. 4th DCA 2018).
[25] *Id.* at 859.
[26] Section 731.201(4), F.S.
[27] Section 733.702(1), F.S.
[28] *Id.* at 853-59.
[29] Chapters 731-735, F.S. *See* s. 731.005, F.S. (providing a short title for the Florida Probate Code).
[30] Real Property, Probate & Trust Law Section of the Florida Bar, *White Paper: The Johnson v. Townsend Fix, Florida Uniform Disposition of Community Property Rights at Death Act (Sections 732.216-732.228, Florida Statutes)*, at 5, undated (on file with the Senate Committee on Judiciary).
[31] *Id.*
[32] *Id.*
[33] Section 28.223, F.S.
[34] Section 28.223(1), F.S.
[35] *Id.*

Most of the documents that must be recorded do not list the heirs in an estate.[36] In a testate estate, the will and any codicils are recorded, thereby evidencing the heirs to an estate, but there are situations where the beneficiaries named in the will differ from the heirs or beneficiaries indicated in the petition, due to (for example):

- The death of a beneficiary.
- An invalid devise of homestead property.
- Disclaimers.
- Non-existent beneficiaries (*e.g.* an incorrectly named charity).[37]

In an intestate estate, there is no will to record, so there is often no indication in the land records of who the heirs to the estate are. The only resource available to determine heirs is to physically appear at the Clerk of the Circuit Court's office and inspect the court docket. However, clerks often destroy court documents, in some cases as soon as 10 years after the case is closed, thereby eliminating publicly accessible documents that could provide vital information regarding the heirs to an intestate estate. For the heirs or their descendants to later convey property owned by the decedent, a costly court determination of heir may be required.[38]

III. Effect of Proposed Changes:

Florida Uniform Disposition of Community Property Rights at Death Act

Nothing in the Florida Disposition of Community Property Rights Act requires a surviving spouse to make a probate creditor claim to preserve his or her community property rights. However, the *Johnson* court held that probate creditor claim procedures do apply to title disputes arising under the Act, including the statute of limitations period and the two-year statute of repose applicable to such claims.

The bill amends and repeals various provisions of the Act, and other related provisions of the Florida Probate Code, to provide that probate creditor claim procedures should not apply to title disputes arising under the Act.

Section 2 of the bill amends s. 732.217, F.S., which identifies the property acquired by a married person to which the Act applies at his or her death, to clarify that personal property held as tenants by the entirety[39] and homestead property is not property to which the Act applies.

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[36] Real Property, Probate & Trust Law Section of the Florida Bar, *White Paper: Proposal to Amend s. 28.223, Fla. Stat. (Probate Records; recordation)*, at 1, undated (on file with the Senate Committee on Judiciary).
[37] *Id.*
[38] *Id.*
[39] "A tenancy by the entireties, as defined by applicable Florida law, is a unique form of property ownership that only married couples may enjoy. Generally, an estate by the entireties is the estate created at common law by a conveyance or a devise of property to spouses. By reason of their legal unity by marriage, the married couple takes the whole estate as a single person with the right of survivorship as an incident thereto so that if one dies, the entire estate belongs to the other by virtue of the original title. … In a tenancy by the entireties, both parties are obligated for the whole of any expenses or debt on the property, including mortgage payments and insurance. However, in Florida, property held by a tenancy by the entireties is exempt from process to satisfy individual obligations of either spouse and may be reached only by a joint creditor of both spouses." 12 FLA. JUR. 2D, *Cotenancy and Partition* s. 18.

Section 3 of the bill amends s. 732.218, F.S., which identifies rebuttable presumptions used to determine whether the Act applies to specific property, to eliminate an unnecessary double negative.

Section 4 of the bill amends s. 732.219, F.S., which governs the disposition of property upon death, to clarify existing law and reduce the risk of unintended forfeitures of the property rights the Act is intended to preserve.

Specifically, the bill:

- Clarifies that one-half of the property to which the Act applies is not property of the decedent's probate estate.
- Clarifies that one-half of the property to which the Act applies is the decedent's probate estate.
- Defines the term "probate estate" to mean all property wherever located that is subject to estate administration in any state of the U.S. or in the District of Columbia.

The bill also incorporates waiver language, providing that if not previously waived pursuant to state law,[40] the right of a surviving spouse to assert a claim arising under the Act, to any right, title, or interest in any property held by the decedent at the time of his or her death may be waived, wholly or partly, by a written contract, agreement, or waiver, signed by the surviving spouse, or any person acting on behalf of a surviving spouse, including, but not limited to, an attorney in fact; agent; guardian of the property; or personal representative, if the written contract, agreement, or waiver includes the following or substantially similar language:

> By executing this contract, agreement, or waiver, I intend to waive my right as a surviving spouse to assert a claim to any right, title, or interest in property held by the decedent at the time of the decedent's death arising under the Florida Uniform Disposition of Community Property Rights at Death Act (ss. 732.216-732.228, Florida Statutes), wholly or partly, as provided herein.

Section 5 of the bill repeals s. 732.221, F.S., which authorizes the personal representative or a beneficiary of the decedent to institute an action to perfect title to property held by the surviving spouse at the time of the decedent's death.

Section 6 of the bill creates s. 732.2211, F.S., entitled "Demands or disputes; statute of repose," which in effect replaces s. 732.221, F.S., to address the uncertainties created by the *Johnson v. Townsend* decision.

Specifically, the bill provides that any demand or dispute arising, wholly or partly, under the Act, regarding any right, title, or interest in any property held by the decedent or surviving spouse at the time of the decedent's death must be determined in an action for declaratory relief governed by the rules of civil procedure. Notwithstanding any other law, a complaint for such action must be filed within two years after the decedent's death or be forever barred. An action for declaratory relief instituted pursuant to the dispute resolution procedures in this section is not a

[40] *See* s. 732.702, F.S. (authorizing the waiver of spousal rights in connection with contractual arrangements relating to death).

claim, as defined in the Florida Probate Code, and is not subject to part VII of chapter 733, F.S, relating to Creditors' Claims.

The bill also provides that the personal representative or curator has no duty to discover whether property held by the decedent or surviving spouse at the time of the decedent's death is property to which the Act applies, or may apply, unless a written demand is made by:

- The surviving spouse or a beneficiary within six months after service of a copy of the notice of administration on the surviving spouse or beneficiary.
- A creditor, except as provided in the next paragraph, within three months after the time of the first publication of the notice to creditors.
- A creditor required to be served with a copy of the notice to creditors, within the later of 30 days after the date of service on the creditor or the time under the previous paragraph.

The bill also provides that the rights of any interested person who fails to timely file an action for declaratory relief pursuant to this section are forfeited. The decedent's surviving spouse, personal representative or curator, or any other person or entity that at any time is in possession of any property to which the act applies, or may apply, may not be subject to liability for any such forfeit rights. The decedent's personal representative or curator may distribute the assets of the decedent's estate without liability for any such forfeit rights.

The bill provides that the section does not affect any issue or matter not arising, wholly or partly, under the Act.

Section 7 of the bill repeals s. 732.223, F.S., which authorizes the probate court to perfect title to property held by the decedent at the time of the decedent's death in the surviving spouse, by an order of the court or by execution of an instrument by the personal representative or beneficiaries of the decedent with approval of the court.

Section 8 of the bill creates s. 732.2231, F.S., entitled "Protection of payors and other third parties," which in effect replaces s. 732.223, F.S., to establish new protections for third parties transferring property subject to the Act.

The bill provides that a property interest is subject to property rights under the Act; however, a payor or other third party is not liable for paying, distributing, or transferring such property to a beneficiary designated in a governing instrument, or for taking any other action in good faith reliance on the validity of a governing instrument.

The bill also defines the following terms for purposes of this section:

- "Governing instrument" means a deed; will; trust; insurance or annuity policy; account with payable-on-death designation; security registered in beneficiary form (TOD); pension, profit-sharing, retirement, or similar benefit plan; an instrument creating or exercising a power of appointment or a power of attorney; or a dispositive, appointive, or nominative instrument of any similar type.[41]
- "Payor" means the decedent's personal representative, a trustee of a trust created by the decedent, an insurer, business entity, employer, government, governmental agency or

[41] *See* s. 732.2025(4), F.S. (defining same for purposes of the bill).

subdivision, or any other person authorized or obligated by law or a governing instrument to make payments.
- "Person" includes an individual, trust, estate, partnership, association, company, or corporation.[42]

Section 9 of the bill amends s. 732.225, F.S., which regulates the acts of married persons, to provide that the reinvestment of any property covered by the Act, in real property in this state which becomes real or personal property held by tenants by the entirety, creates a conclusive presumption that the spouses have agreed to terminate the community property attribute of the property reinvested.

Section 10 of the bill amends s. 732.702, F.S., which regulates the waiver of spousal rights in connection with contractual arrangements relating to death, to make the right of a surviving spouse to assert a claim under the Act waivable, in whole or in part, before or after marriage, by a written contract, agreement, or waiver, signed by the waiving party in the presence of two subscribing witnesses.

Section 11 of the bill amends s. 733.212, F.S., which regulates notices of administration and the filing of objections in connection with commencing the administration of probate, to require such notices to state that the personal representative or curator has no duty to discover whether any property held at the time of the decedent's death by the decedent or the decedent's surviving spouse is property to which the Act applies, or may apply, unless a written demand is made by the surviving spouse or a beneficiary as specified under the bill.[43] Currently, notices of administration do not provide notice of the deadlines triggered under the Act.

Section 12 of the bill amends s. 733.2121, F.S., which regulates notices to creditors and the filing of claims in connection with commencing the administration of probate, to require such notices to state that a personal representative or curator has no duty to discover whether any property held at the time of the decedent's death by the decedent or the decedent's surviving spouse is property to which the Act applies, or may apply, unless a written demand is made by a creditor as specified under the bill.[44] Currently, notices to creditors do not provide notice of the deadlines triggered under the Act.

Section 13 of the bill amends s. 733.607, F.S., which regulates the possession of estates in connection with the duties and powers of personal representatives, to provide that notwithstanding anything in the section, the personal representative has no right to, and may not knowingly take possession or control of, a surviving spouse's one-half share of property to which the Act applies. This amendment is intended to address the uncertainties created by the *Johnson v. Townsend* decision.

[42] *See* s. 732.2025(6), F.S. (defining same for purposes of the bill).
[43] Specifically, s. 6 of the bill creating s. 732.2211, F.S.
[44] *Id.*

Recordation of Probate Records

Section 1 of the bill amends, effective January 1, 2025, s. 28.223, F.S., which governs the recordation of probate records, to require the clerk of the circuit court to record (in addition to other documents) orders admitting the will to probate and orders determining beneficiaries.

By requiring these documents affecting the inheritance of real property to be recorded, evidence of heirship will be preserved in the Official Records, where documents are not destroyed and should be easily and publicly accessible to anyone searching title as to the real property.

Effective Date

Section 14 of the bill provides that except as otherwise expressly provided in the bill, the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The "announced public policy of this state … requires that estates of decedents be speedily and finally determined."[45] To that end, the bill creates a new dispute resolution mechanism and two-year statute of repose specifically designed for title disputes arising under the Act.[46]

To the extent these changes result in forfeiture of pre-existing testamentary property rights, they are a valid and constitutional exercise of the state's police power in service of

[45] *In re Estate of Gay,* 294 So. 2d 668, 670 (Fla. 4th DCA 1974).
[46] A statute of repose "bar[s] actions by setting a time limit within which an action must be filed as measured from a specified act, after which time the cause of action is extinguished." *Hess v. Philip Morris USA, Inc.*, 175 So. 3d 687, 695 (Fla. 2015) (internal citation and quotations omitted).

a legitimate and reasonably related public policy favoring the speedy and final determination of estate proceedings.[47]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will lower or eliminate the cost of determining heirs after probate documents have been destroyed by the Clerks of the Circuit Court due to the passage of time. The bill provides recorded evidence as to the ownership of real property passing through probate in accordance with the successions laws of this state, thereby avoiding economic loss to the true heirs of the real property and their descendants. Creditor's rights are also affected by the enhanced ability to identify a debtor's interest in real property.

C. Government Sector Impact:

The bill will increase, to some degree, the cost of storing recorded documents. It is anticipated this cost is minimal and will be absorbed by the Clerk of Circuit Courts' existing budgets.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 28.223, 732.217, 732.218, 732.219, 732.225, 732.702, 733.212, 733.2121, and 733.607.

This bill creates the following sections of the Florida Statutes: 732.2211 and 732.2231.

This bill repeals the following sections of the Florida Statutes: 732.221 and 732.223.

[47] *See In re Estate of Magee,* 988 So. 2d 1, 5-6 (Fla. 1st DCA 2007) (holding that the elective share statute, in permitting a decedent's spouse to accept a statutory share, rather than a testamentary share, of decedent's estate, was rationally related to the legitimate legislative purpose of safeguarding the public welfare, and thus did not violate the state constitutional provision protecting the possession of property).

IX. Additional Information:

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

CS by Banking and Insurance Committee on February 6, 2024:
The committee substitute:

- Removes language in the bill that required the Clerk to record petitions affecting or describing real property; and
- Provides that an action for declaratory relief is not subject to part VII of chapter 733, F.S, relating to Creditors' Claims.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/08/2024	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 61 - 151
and insert:
orders affecting or describing real property, final orders, orders of final discharge, and orders of guardianship filed in the clerk’s office. No other petitions, pleadings, papers, or other orders relating to probate matters shall be recorded except on the written direction of the court. The direction may be in the order by incorporation in the order of the words “To

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be recorded," or words to that effect. Failure to record an order or a judgment does ~~shall~~ not affect its validity.

Section 2. Section 732.217, Florida Statutes, is amended to read:

732.217 Application.—Sections 732.216-732.228 apply to the disposition at death of the following property acquired by a married person:

(1) Personal property, except personal property held as tenants by the entirety, wherever located, which:

(a) Was acquired as, or became and remained, community property under the laws of another jurisdiction;

(b) Was acquired with the rents, issues, or income of, or the proceeds from, or in exchange for, community property; or

(c) Is traceable to that community property.

(2) Real property, except real property held as tenants by the entirety and homestead property, which is located in this state, and which:

(a) Was acquired with the rents, issues, or income of, the proceeds from, or in exchange for, property acquired as, or which became and remained, community property under the laws of another jurisdiction; or

(b) Is traceable to that community property.

Section 3. Subsection (2) of section 732.218, Florida Statutes, is amended to read:

732.218 Rebuttable presumptions.—In determining whether ss. 732.216-732.228 apply to specific property, the following rebuttable presumptions apply:

(2) Real property located in this state~~, other than homestead and real property held as tenants by the entirety,~~ and

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personal property wherever located acquired by a married person while domiciled in a jurisdiction under whose laws property could not then be acquired as community property and title to which was taken in a form which created rights of survivorship are presumed to be property to which these sections do not apply.

Section 4. Section 732.219, Florida Statutes, is amended to read:

732.219 Disposition upon death; waiver.—

(1) Upon the death of a married person, one-half of the property to which ss. 732.216-732.228 apply is the property of the surviving spouse, is not property of the decedent's probate estate, and is not subject to testamentary disposition by the decedent or distribution under the laws of succession of this state. One-half of that property is the property of the decedent's probate estate ~~decedent~~ and is subject to testamentary disposition or distribution under the laws of succession of this state. The decedent's one-half of that property is not in the elective estate. For purposes of this section, the term "probate estate" means all property wherever located, that is subject to estate administration in any state of the United States or in the District of Columbia.

(2) If not previously waived pursuant to s. 732.702, the right of a surviving spouse to assert a claim arising under ss. 732.216-732.228, to any right, title, or interest in any property held by the decedent at the time of his or her death may be waived, wholly or partly, by a written contract, agreement, or waiver, signed by the surviving spouse, or any person acting on behalf of a surviving spouse, including, but

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not limited to, an attorney in fact; agent; guardian of the property; or personal representative, if the written contract, agreement, or waiver includes the following or substantially similar language:

> By executing this contract, agreement, or waiver, I intend to waive my right as a surviving spouse to assert a claim to any right, title, or interest in property held by the decedent at the time of the decedent's death arising under the Florida Uniform Disposition of Community Property Rights at Death Act (ss. 732.216-732.228, Florida Statutes), wholly or partly, as provided herein.

Section 5. Section 732.221, Florida Statutes, is repealed.

Section 6. Section 732.2211, Florida Statutes, is created to read:

732.2211 Demands or disputes; statute of repose.—

(1)(a) Any demand or dispute arising, wholly or partly, under ss. 732.216-732.228, regarding any right, title, or interest in any property held by the decedent or surviving spouse at the time of the decedent's death shall be determined in an action for declaratory relief governed by the rules of civil procedure. Notwithstanding any other law, a complaint for such action must be filed within 2 years after the decedent's death or be forever barred.

(b) An action for declaratory relief instituted pursuant to this section is not a claim, as defined in s. 731.201, and is not subject to ss. 733.701-733.710.

By Senator Powell

24-00455A-24 20241064__

A bill to be entitled

An act relating to wills and estates; amending s. 28.223, F.S.; expanding the types of probate documents that must be recorded; revising a provision for incorporating a certain direction by reference; amending s. 732.217, F.S.; revising the types of property subject to the provisions of a certain act; amending s. 732.218, F.S.; revising the types of property for which there is a rebuttable presumption under a specified act; amending s. 732.219, F.S.; specifying that certain property is either included or excluded from the probate estate at the time of death; defining the term "probate estate"; authorizing specified parties to waive certain property rights; specifying how such rights may be waived; requiring that such waiver include specified language; repealing s. 732.221, F.S., relating to perfection of title of personal representative or beneficiary; creating s. 732.2211, F.S.; providing that demands and disputes arising under a certain act must be determined using a specified action; requiring that such action be governed by specified rules; requiring that such action be filed within a certain period of time; providing construction; providing that certain parties have no duty to discover if property is subject to a specified act; providing exceptions; providing that certain rights are forfeited if specified actions are not taken; prohibiting certain parties from being held liable in specified circumstances; providing

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construction; repealing s. 732.223, F.S., relating to perfection of title of surviving spouses; creating s. 732.2231, F.S.; providing definitions; providing that certain parties are not liable for specified actions taken regarding property subject to a certain act; amending s. 732.225, F.S.; expanding the types of property for which there is a certain conclusive presumption; amending s. 732.702, F.S.; expanding the types of rights which may be waived by a surviving spouse; expanding the types of rights considered to be "all rights" within a waiver; amending s. 733.212, F.S.; requiring that a notice of administration state that specified parties have no duty to discover if property is subject to a certain act; providing an exception; amending s. 733.2121, F.S.; requiring that a notice to creditors state that specified parties have no duty to discover if property is subject to a certain act; providing an exception; amending s. 733.607, F.S.; specifying that specified parties have no rights to, and may not take possession of, certain property; providing effective dates.

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

Section 1. Effective January 1, 2025, subsection (1) of section 28.223, Florida Statutes, is amended to read:

28.223 Probate records; recordation.—

(1) The clerk of the circuit shall record all wills and codicils admitted to probate, orders admitting the will to

probate, orders determining beneficiaries, orders revoking the probate of any wills and codicils, letters of administration, petitions and orders affecting or describing real property, final orders, orders of final discharge, and orders of guardianship filed in the clerk's office. No other petitions, pleadings, papers, or other orders relating to probate matters shall be recorded except on the written direction of the court. The direction may be in the order by incorporation in the order of the words "To be recorded," or words to that effect. Failure to record an order or a judgment shall not affect its validity.

Section 2. Section 732.217, Florida Statutes, is amended to read:

732.217 Application.—Sections 732.216-732.228 apply to the disposition at death of the following property acquired by a married person:

(1) Personal property, except personal property held as tenants by the entirety, wherever located, which:

(a) Was acquired as, or became and remained, community property under the laws of another jurisdiction;

(b) Was acquired with the rents, issues, or income of, or the proceeds from, or in exchange for, community property; or

(c) Is traceable to that community property.

(2) Real property, except real property held as tenants by the entirety and homestead property, which is located in this state, and which:

(a) Was acquired with the rents, issues, or income of, the proceeds from, or in exchange for, property acquired as, or which became and remained, community property under the laws of another jurisdiction; or

(b) Is traceable to that community property.

Section 3. Subsection (2) of section 732.218, Florida Statutes, is amended to read:

732.218 Rebuttable presumptions.—In determining whether ss. 732.216-732.228 apply to specific property, the following rebuttable presumptions apply:

(2) Real property located in this state~~, other than homestead and real property held as tenants by the entirety,~~ and personal property wherever located acquired by a married person while domiciled in a jurisdiction under whose laws property could not then be acquired as community property and title to which was taken in a form which created rights of survivorship are presumed to be property to which these sections do not apply.

Section 4. Section 732.219, Florida Statutes, is amended to read:

732.219 Disposition upon death; waiver.—

(1) Upon the death of a married person, one-half of the property to which ss. 732.216-732.228 apply is the property of the surviving spouse, is not property of the decedent's probate estate, and is not subject to testamentary disposition by the decedent or distribution under the laws of succession of this state. One-half of that property is the property of the decedent's probate estate ~~decedent~~ and is subject to testamentary disposition or distribution under the laws of succession of this state. The decedent's one-half of that property is not in the elective estate. For purposes of this section, the term "probate estate" means all property wherever located, that is subject to estate administration in any state

of the United States or in the District of Columbia.

(2) If not previously waived pursuant to s. 732.702, the right of a surviving spouse to assert a claim arising under ss. 732.216-732.228, to any right, title, or interest in any property held by the decedent at the time of his or her death may be waived, wholly or partly, by a written contract, agreement, or waiver, signed by the surviving spouse, or any person acting on behalf of a surviving spouse, including, but not limited to, an attorney in fact; agent; guardian of the property; or personal representative, if the written contract, agreement, or waiver includes the following or substantially similar language:

"By executing this contract, agreement, or waiver, I intend to waive my right as a surviving spouse to assert a claim to any right, title, or interest in property held by the decedent at the time of the decedent's death arising under the Florida Uniform Disposition of Community Property Rights at Death Act (ss. 732.216-732.228, Florida Statutes), wholly or partly, as provided herein."

Section 5. Section 732.221, Florida Statutes, is repealed.

Section 6. Section 732.2211, Florida Statutes, is created to read:

732.2211 Demands or disputes; statute of repose.—

(1)(a) Any demand or dispute arising, wholly or partly, under ss. 732.216-732.228, regarding any right, title, or interest in any property held by the decedent or surviving spouse at the time of the decedent's death shall be determined in an action for declaratory relief governed by the rules of

civil procedure. Notwithstanding any other law, a complaint for such action must be filed within 2 years after the decedent's death or be forever barred.

(b) An action for declaratory relief instituted pursuant to this section is not a claim, as defined in s. 731.201, and is not subject to the provisions of s. 733.702(1) or s. 733.710.

(2) The personal representative or curator has no duty to discover whether property held by the decedent or surviving spouse at the time of the decedent's death is property to which ss. 732.216-732.228 apply, or may apply, unless a written demand is made by:

(a) The surviving spouse or a beneficiary within 6 months after service of a copy of the notice of administration on the surviving spouse or beneficiary.

(b) A creditor, except as provided in paragraph (c), within 3 months after the time of the first publication of the notice to creditors.

(c) A creditor required to be served with a copy of the notice to creditors, within the later of 30 days after the date of service on the creditor or the time under paragraph (b).

(3) The rights of any interested person who fails to timely file an action for declaratory relief pursuant to this section are forfeited. The decedent's surviving spouse, personal representative or curator, or any other person or entity that at any time is in possession of any property to which ss. 732.216-732.228 apply, or may apply, shall not be subject to liability for any such forfeit rights. The decedent's personal representative or curator may distribute the assets of the decedent's estate without liability for any such forfeit rights.

(4) This section does not affect any issue or matter not arising, wholly or partly, under ss. 732.216-732.228.

Section 7. Section 732.223, Florida Statutes, is repealed.

Section 8. Section 732.2231, Florida Statutes, is created to read:

732.2231 Protection of payors and other third parties.—

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

(a) "Governing instrument" has the same meaning as in s. 732.2025.

(b) "Payor" means the decedent's personal representative, a trustee of a trust created by the decedent, an insurer, business entity, employer, government, governmental agency or subdivision, or any other person authorized or obligated by law or a governing instrument to make payments.

(c) "Person" has the same meaning as in s. 732.2025.

(2) A property interest is subject to property rights under ss. 732.216-732.228, however, a payor or other third party is not liable for paying, distributing, or transferring such property to a beneficiary designated in a governing instrument, or for taking any other action in good faith reliance on the validity of a governing instrument.

Section 9. Section 732.225, Florida Statutes, is amended to read:

732.225 Acts of married persons.—Sections 732.216-732.228 do not prevent married persons from severing or altering their interests in property to which these sections apply. The reinvestment of any property to which these sections apply in real property located in this state which is or becomes real or personal property held by tenants by the entirety or homestead

property creates a conclusive presumption that the spouses have agreed to terminate the community property attribute of the property reinvested.

Section 10. Subsection (1) of section 732.702, Florida Statutes, is amended to read:

732.702 Waiver of spousal rights.—

(1) The rights of a surviving spouse to an elective share, intestate share, pretermitted share, homestead, exempt property, family allowance, or to assert a claim under the Florida Uniform Disposition of Community Property Rights at Death Act as described in ss. 732.216-732.228, and preference in appointment as personal representative of an intestate estate or any of those rights, may be waived, wholly or partly, before or after marriage, by a written contract, agreement, or waiver, signed by the waiving party in the presence of two subscribing witnesses. The requirement of witnesses shall be applicable only to contracts, agreements, or waivers signed by Florida residents after the effective date of this law. Any contract, agreement, or waiver executed by a nonresident of Florida, either before or after this law takes effect, is valid in this state if valid when executed under the laws of the state or country where it was executed, whether or not he or she is a Florida resident at the time of death. Unless the waiver provides to the contrary, a waiver of "all rights," or equivalent language, in the property or estate of a present or prospective spouse, or a complete property settlement entered into after, or in anticipation of, separation, dissolution of marriage, or divorce, is a waiver of all rights to elective share, intestate share, pretermitted share, homestead, exempt property, family allowance, or to

assert a claim under the Florida Uniform Disposition of Community Property Rights at Death Act as described in ss. 732.216-732.228, and preference in appointment as personal representative of an intestate estate, by the waiving party in the property of the other and a renunciation by the waiving party of all benefits that would otherwise pass to the waiving party from the other by intestate succession or by the provisions of any will executed before the written contract, agreement, or waiver.

Section 11. Paragraph (g) is added to subsection (2) of section 733.212, Florida Statutes, to read:

733.212 Notice of administration; filing of objections.—

(2) The notice shall state:

(g) That the personal representative or curator has no duty to discover whether any property held at the time of the decedent's death by the decedent or the decedent's surviving spouse is property to which the Florida Uniform Disposition of Community Property Rights at Death Act as described in ss. 732.216-732.228 applies, or may apply, unless a written demand is made by the surviving spouse or a beneficiary as specified under s. 732.2211.

Section 12. Subsection (1) of section 733.2121, Florida Statutes, is amended to read:

733.2121 Notice to creditors; filing of claims.—

(1) Unless creditors' claims are otherwise barred by s. 733.710, the personal representative shall promptly publish a notice to creditors. The notice shall contain the name of the decedent, the file number of the estate, the designation and address of the court in which the proceedings are pending, the

name and address of the personal representative, the name and address of the personal representative's attorney, and the date of first publication. The notice shall state that creditors must file claims against the estate with the court during the time periods set forth in s. 733.702, or be forever barred. The notice shall state that a personal representative or curator has no duty to discover whether any property held at the time of the decedent's death by the decedent or the decedent's surviving spouse is property to which the Florida Uniform Disposition of Community Property Rights at Death Act as described in ss. 732.216-732.228, applies, or may apply, unless a written demand is made by a creditor as specified under s. 732.2211.

Section 13. Subsection (1) of section 733.607, Florida Statutes, is amended to read:

733.607 Possession of estate.—

(1) Except as otherwise provided by a decedent's will, every personal representative has a right to, and shall take possession or control of, the decedent's property, except the protected homestead, but any real property or tangible personal property may be left with, or surrendered to, the person presumptively entitled to it unless possession of the property by the personal representative will be necessary for purposes of administration. The request by a personal representative for delivery of any property possessed by a beneficiary is conclusive evidence that the possession of the property by the personal representative is necessary for the purposes of administration, in any action against the beneficiary for possession of it. The personal representative shall take all steps reasonably necessary for the management, protection, and

preservation of the estate until distribution and may maintain an action to recover possession of property or to determine the title to it. Notwithstanding anything in this section, the personal representative has no right to, and shall not knowingly take possession or control of, a surviving spouse's one-half share of property to which the Florida Uniform Disposition of Community Property Rights at Death Act as described in ss. 732.216-732.228, applies.

Section 14. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Banking and Insurance
Committee

SB 1064
Bill Number or Topic

Amendment Barcode (if applicable)

Name Martha Edenfield

Phone 850-241-5100

Address 106 E. College Ave #1200
Street

Email medenfield@deanmead.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
The Real Property, Probate and Trust Law Section of the Florida Bar.

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd
Committee on Banking & Insurance

Subject: Committee Agenda Request

Date: January 29, 2024

I respectfully request that **Senate Bill #1064**, relating to **Wills and Estates**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Bobby Powell
Florida Senate, District 24

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1064
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/06/2024 adopted 1 Powell					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
VA		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1338
INTRODUCER:	Banking and Insurance Committee and Senator DiCeglie
SUBJECT:	Pet Insurance
DATE:	February 8, 2024 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1338 creates a regulatory framework for the oversight of pet insurance by the Office of Insurance Regulation (OIR). The bill provides consumer protections, including policy disclosures regarding the benefits and exclusions, and a right to rescind a policy within 30 days of issuance.

Although pet insurance is considered a kind of property insurance, it is essentially a health insurance policy for a pet that covers accidents and illnesses. In the United States about 65 million households have a dog and 46 million have a cat, and 4.8 million cats and dogs are insured in this country.[1] In 2022, total, nationwide premiums for pet insurance were about $2.8 billion and covering over 4.41 million pets.[2] This represents an increase of 30.5 percent more premiums than in 2020 and about 28 percent more pets insured than in 2020.[3]

II. Present Situation:

Regulation of Insurance in Florida

Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S., constitute the Florida Insurance Code (code). Part III of ch. 624, F.S., prescribes the requirements for an entity to obtain a

[1] Pet Insurance Buying Guide - Consumer Reports (Aug. 25, 2023) (last visited Jan. 12, 2023).
[2] NAIC Passes Pet Insurance Model Act | Insurance Advocate (insurance-advocate.com) (Sep. 10, 2022) (last visited Jan. 14, 2024). This data was provided by North American Pet Health Insurance Association (NAPHIA).
[3] *Id.*

certificate of authority and be authorized as an insurer. Part V of ch. 624, F.S., defines the kinds of insurance, including property insurance. Part I of ch. 626, F.S., regulates insurance agents, and Part III of ch. 626, F.S., regulates general lines agents. Part I of ch. 627, F.S., known as the "Rating Law," provides that a purpose of this part is to promote the public welfare by regulating insurance rates to the end that they may not be excessive, inadequate, or unfairly discriminatory. Part X of ch. 617, F.S., regulates property insurance.

Department of Financial Services

The powers and duties of the Chief Financial Officer and the Department of Financial Services (DFS), relating to part I of ch. 626, F.S., are specified in s. 626.016, F.S. Part I, known as the "The Licensing Procedures Law,[4] applies only with respect to insurance agents, insurance agencies, managing general agents, insurance adjusters, reinsurance intermediaries, viatical settlement brokers, customer representatives, service representatives, and agencies. The powers and duties of the commission and OFR specified in Part I apply only with respect to service companies, administrators, and viatical settlement providers and contracts.

Licensure of Insurance Agents

Section 626.112, F.S., provides that no person may be, act as, or advertise or hold himself or herself out to be an insurance agent, insurance adjuster, or customer representative unless he or she is currently licensed by the DFS and appointed by an appropriate appointing entity or person. An agent is a general lines agent, life agent, health agent, or title agent, or all such agents, as indicated by context.[5] Part II of ch. 626, F.S., regulates general lines agents. A general lines agent is an agent transacting nay of the following kinds of insurance:

- Property insurance.
- Casualty insurance.
- Surety insurance.
- Health insurance.
- Marine insurance.[6]

As a condition of transacting insurance in this state, agents must comply with consumer protection laws, including the following, as applicable:[7]

- Continuing education requirements for resident and nonresident agents, as required in s. 626.2815.
- Fingerprinting requirements for resident and nonresident agents, as required under s. 626.171 or s. 626.202.
- Fingerprinting following a department investigation under s. 626.601.
- The submission of credit and character reports, as required by s. 626.171.
- Qualifications for licensure as an agent in s. 626.731, s. 626.741, s. 626.785, s. 626.792, s. 626.831, or s. 626.835.
- Examination requirements in s. 626.221, s. 626.741, s. 626.792, or s. 626.835.

[4] Section 626.011, F.S.
[5] Section 626.015(3), F.S.
[6] Section 626.015(7), F.S.,
[7] Section 626.025, F.S.

- Required licensure or registration of insurance agencies under s. 626.112.
- Requirements for licensure of resident and nonresident agents in s. 626.112, s. 626.321, s. 626.731, s. 626.741, s. 626.785, s. 626.792, s. 626.831, s. 626.835, or s. 626.927.
- Countersignature of insurance policies, as required under s. 624.425, s. 624.426, or s. 626.741.
- The code of ethics for life insurance agents, as set forth in s. 626.797.
- Any other licensing requirement, restriction, or prohibition designated a consumer protection by the Chief Financial Officer, but not inconsistent with the requirements of Subtitle C of the federal Gramm-Leach-Bliley Act.

The Office of Insurance Regulation

The Office of Insurance Regulation (OIR) is responsible for regulating all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the code. The head of the OIR is the Commissioner.[8]

The Unfair Insurance Trade Practices Act (Act)

The Act [9] regulates trade practice relating to the business of insurance, including activities of insurers and agents. The department and the office are authorized to impose fines on any person who violates any provision of this Act.[10]

National Association of Insurance Commissioners

The OIR is a member of the National Association of Insurance Commissioners (NAIC), an organization consisting of state insurance regulators.[11] As a member of the NAIC, OIR is required to participate in the organization's accreditation program.[12] NAIC accreditation is a certification that a state insurance department is fulfilling legal, regulatory, and organizational oversight standards and practices. Once accredited, a member state is subject to a full accreditation review every five years. The NAIC also periodically reviews its solvency standards as set forth in its model acts, and revises accreditation requirements to adapt to evolving industry standards.

Pet Insurance Act

[8] Section 20.121(3)(a)1, F.S. The Financial Services Commission (commission), composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serve as the commission. Commission members serve as agency head of the Financial Services Commission. Commission members shall serve as the agency head for purposes of rulemaking by the commission. Section 20.121(3)(c), F.S.
[9] Part IX, ch. 626, F.S.
[10] *Id.*
[11] The NAIC provides expertise, data, and analysis for insurance commissioners to effectively regulate the industry and protect consumers. Founded in 1871, the U.S. standard-setting organization is governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories to coordinate regulation of multistate insurers. About (naic.org) (last visited Jan. 14, 2024).
[12] Accreditation, NAIC, (May 31, 2023). https://content.naic.org/cipr_topics/topic_accreditation.htm (last visited Jan. 14, 2024).

In 2022, the National Association of Insurance Commissioners (NAIC) adopted the Pet Insurance Model Law, also known as the "Pet Insurance Act" (act).[13] The purpose of this act is to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold. The elements of the act include definitions, disclosures, policy conditions, sales practices for wellness programs, agent training, rulemaking, and violations. As of the summer of 2022, only one state, Maine, had adopted the Act.[14] California enacted legislation to regulate pet insurance that contains provisions similar to the act, and also provides civil penalties for nonwillful violations and willfull violations.[15]

Prior to the NAIC's approval of the model law, the following factors were cited as the impetus for NAIC to form a property and casualty insurance task force initially to review pet insurance coverage, product approval, marketing, ratemaking, claims practices, and regulatory concerns:

- Tremendous growth in the pet insurance market;
- Policy premiums that far exceed the cost of the covered pet; and
- Complex policies with multiple coverage options and exclusions.

The NAIC task force issued, A Regulator's Guide to Pet Insurance in 2019. The report found that in 2018:

- The largest amount of gross premium was concentrated in California (21.4 percent) and New York (10.4 percent). In contrast, Florida's represented 6.3 percent of the gross written premium.[16]
- The first pet policy was issued in the U.S. in 1982.
- The majority of the carriers selling policies offer the following coverage: accident only; and accident and illness.
- Most carriers write coverage for dogs and cats only. Some write policies for exotic pets, such as reptiles and birds. Many carriers exclude coverage for pets less than eight weeks old or older than 12 years.
- Some carriers have waiting periods for injury, illness, and orthopedic care. Policy exclusions were noted for preexisting conditions. Many policies exclude coverage for congenital and hereditary conditions, such as hip dysplasia, heart defects, cataracts, and diabetes.
- The most common marketing or distribution strategies were web based marketing and referrals from veterinary clinics, friends, and families. The fastest growing form of distribution was through an employee benefit package.

[13] NAIC Pet Insurance Model Law_11921Clean (soutronglobal.net), Model 633 (Aug. 2022) (last visited Jan. 12, 2024).
[14] ST880 (soutronglobal.net) (last visited Jan. 12, 2024).
[15] A maximum of $5,000 for each nonwillful violation and $10,000 for each willful violation. See California AB 2056, Chapter 986, and effective July 1, 2015. California Code of Insurance 12880-12880.4.
[16] NAIC, A Regulator's Guide to Pet Insurance (2019), publication-pin-op-pet-insurance.pdf (naic.org) (last visited Jan. 12, 2024). This data was provided by NAPHIA, not the states or the NAIC. Such data includes NAPHIA members only and is not exhaustive of the entire market for pet insurance. The report notes that NAPHIA represents 99 percent of the U.S. and Canada pet insurance industry.

Consumer Reports[17] conducted a member survey[18] of 2,061 members who insured their pets. The average premium paid by CR members was $47 per month per pet. Depending on the plan selected, deductibles can range from $0 to $1,000 or more. Copays (the fixed percentage of a vet bill that is paid out of pocket) are typically 20 percent.[19]

Regulation of Veterinarians in Florida

Veterinary Medicine, the Practice of Veterinary Medicine

In 1979, the Legislature determined the practice of veterinary medicine to be potentially dangerous to public health and safety if conducted by incompetent and unlicensed practitioners and that minimum requirements for the safe practice of veterinary medicine are necessary.[20] The Board of Veterinary Medicine in the Department of Business and Professional Regulation implements the provisions of ch. 474, F.S., on Veterinary Medical Practice.[21] A veterinarian is a health care practitioner licensed to engage in the practice of veterinary medicine in Florida under ch. 474, F.S.[22] In Fiscal Year 2021-2022, there were 12,360 actively licensed veterinarians in Florida.[23]

Veterinary medicine[24] includes, with respect to animals:[25]
- Surgery;
- Acupuncture;
- Obstetrics;
- Dentistry;
- Physical therapy;
- Radiology;
- Theriogenology (reproductive medicine);[26] and
- Other branches or specialties of veterinary medicine.

The practice of veterinary medicine is the diagnosis of medical conditions of animals, and the prescribing or administering of medicine and treatment to animals for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease, or holding oneself out as performing any of

[17] What We Do - Consumer Reports (last visited Jan. 14, 2024). Consumer Reports is an independent, nonprofit member organization that works side by side with consumers for truth, transparency, and fairness in the marketplace. Consumer Reports was founded in 1936.
[18] Pet Insurance Buying Guide - Consumer Reports (Aug. 25, 2023) (last visited Jan. 12, 2024).

[20] *See* s. 474.201, F.S.
[21] S*ee* s. 474.204 through 474.2125, F.S., concerning the powers and duties of the board.
[22] See s. 474.202(11), F.S.
[23] *See* Department of Business and Professional Regulation, *Division of Professions Annual Report Fiscal Year 2021-2022*, at page 18, at http://www.myfloridalicense.com/DBPR/os/documents/Division%20Annual%20Report%20FY%2021-22.pdf (last visited Jan. 4, 2024), which is the latest such Annual Report issued by the DBPR.
[24] *See* s. 474.202(13), F.S.
[25] Section 474.202(1), F.S., defines "animal" as "any mammal other than a human being or any bird, amphibian, fish, or reptile, wild or domestic, living or dead."
[26] The Society for Theriogenology, established in 1954, is composed of veterinarians dedicated to standards of excellence in animal reproduction. *See* https://www.therio.org/ (last visited Jan. 4, 2024).

these functions.[27] Veterinarians who are incompetent or present a danger to the public are subject to discipline and may be prohibited from practicing in the state.[28]

III. Effect of Proposed Changes:

Section 1. Amends s. 624.604, F.S., to provide that property insurance may include pet insurance that provides coverage for accidents and for illnesses or diseases of pets.

Section 2. Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts, to add the following sales practices for pet wellness programs:

- A pet insurer or an insurance producer may not market a wellness program as pet insurance.
- If a wellness program is sold by a pet insurance agent:
  - The purchase of the wellness program may not be a requirement for the purchase of pet insurance;
  - The costs of the wellness program must be separate and identifiable from any pet insurance policy sold by a pet insurer or an insurance producer;
  - The terms and conditions for the wellness program must be separate from any pet insurance policy sold by a pet insurer or an insurance producer;
  - The products or coverages available through the wellness program may not duplicate products or coverages available through the pet insurance policy; and
  - The advertising of the wellness program must not be misleading.

Section 3. Creates s. 627.71545, F.S., relating to pet insurance and noninsurance wellness programs. This section may be cited as the "Pet Insurance Act." The section states that the purpose of this section is to promote the public welfare by creating a comprehensive regulatory framework within which pet insurance may be sold in this state. The section states that this chapter applies to the following:

- Pet insurance policies that are issued to any resident of this state or that are sold, solicited, negotiated, or offered in this state.
- Pet insurance policies or certificates that are delivered or issued for delivery in this state.
- All other applicable provisions of the insurance laws of this state continue to apply to pet insurance except that the specific provisions of this chapter supersede any general provisions of law which would otherwise be applicable to pet insurance.

This section may not be construed to prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions as specified in subsection (9).

The section provides the following definitions:

- "Chronic condition" means a condition that can be treated or managed, but not cured.
- "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

[27] Section 474.201, F.S. *See* s. 474.202(9), F.S. Also included is the determination of the health, fitness, or soundness of an animal, and the performance of any manual procedure for the diagnosis or treatment of pregnancy, fertility, or infertility of animals.

[28] *See* s. 474.213, F.S., on prohibited acts, and s. 474.214, F.S., on disciplinary proceedings.

- "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.
- "Orthopedic" refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, or joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.
- "Pet insurance" means a property insurance policy that provides coverage for accidents and for illnesses and diseases of pets. Such insurance reimburses a policyholder for expenses associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by the veterinarian.
- "Preexisting condition" means any condition for which any of the following are true before the effective date of a pet insurance policy or during any waiting period:
  - A veterinarian provided medical advice.
  - The pet received treatment.
  - Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

  A condition for which coverage is afforded on a policy is not deemed to be a preexisting condition on any renewal of the policy.

- "Renewal" means the issuance and delivery at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.
- "Veterinarian" means a health care practitioner who is licensed to engage in the practice of veterinary medicine in Florida under chapter 474, F.S..
- "Waiting period" means the period of time specified in a pet insurance policy which is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.
- "Wellness program" means a subscription-based or reimbursement-based program that is separate from an insurance policy which provides goods and services to promote the general health, safety, or well-being of the pet.

The bill specifies that when the foregoing defined terms are used in a pet insurance policy, they must be defined pursuant to the statute. The pet insurer must include any such definitions used in polices available via a clear and conspicuous link on the main page of pet insurer's website.

The bill requires a pet insurer transacting pet insurance to disclose the following to pet insurance applicants and policyholders:

- Whether the policy excludes coverage due to any of the following:
  - A preexisting condition;
  - A hereditary disorder;
  - A congenital anomaly or disorder or
  - A chronic condition.

- If the policy includes any other policy exclusions not listed above, the pet insurer must state the following in the disclosure: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."
- Any policy provision that limits coverage through a waiting period, a deductible, coinsurance, or an annual or lifetime policy limit. Waiting periods and the requirements applicable to them must be clearly and prominently disclosed to consumers before the policy purchase.
- Whether the pet insurer reduces coverage or increases premiums based on the policyholder's claim history, the age of the covered pet, or a change in the geographic location of the policyholder.
- Whether the underwriting company differs from the brand name used to market and sell the product.

Prior to issuing a pet insurance policy, a pet insurer is required to provide through a clear and conspicuous link on the main page of the pet insurer's website or the website of the insurer's program administrator, a summary description of the basis or formula for the pet insurer's determination of claim payments under the policy.

- If a pet insurer uses a benefit schedule to determine claim payments under a pet insurance policy, the insurer must clearly disclose the following:
  - The applicable benefit schedule in the policy; and
  - All benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.
- If a pet insurer uses usual and customary payments to determine claims payments under a pet insurance policy, or any other reimbursement limitation based on prevailing veterinary service provider charges, the insurer must:
  - Include a usual and customary fee limitation provision in the policy which clearly describes the pet insurer's basis or formula for determining usual and customary fees and how that basis or formula is applied in calculating claim payments.
  - Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

If any medical examination by a veterinarian is required to effectuate coverage, the pet insurer must clearly and conspicuously disclose the required aspects of the examination before the policy is purchased and must disclose that examination documentation may result in a preexisting condition exclusion.

Insurer Disclosure of Important Policy Provisions

At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer must provide the policyholder with a copy of the Insurer Disclosure of Important Policy Provisions, which provides a summary of the required disclosures. Further, the pet insurer must post the document by way of a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website. The pet insurer must also include a written disclosure with all of the following information:

- Contact information for the Division of Consumer Services of the Department of Financial Services, including a toll-free telephone number and a link.
- The address and customer service telephone number of the pet insurer or the insurance agent.

Right to Return Policy

A pet insurance policy and rider must have a notice prominently printed on the first page or attached, which includes specific instructions to accomplish a return. If a policyholder decides not to keep the policy, the policyholder must return it to the insurer at its administrative office or return it to the agent/insurance producer unless the policyholder has filed a claim. The policyholder's right to return the policies lasts 30 days after the date of receipt. The insurer must refund the full amount of any premium paid within 30 days after receipt of the returned policy, certificate, or rider. The premium refund must be sent directly to the person who paid it. The policy, certificate, or rider will be void as if it had never been issued. The notice must state in substantially form, the following:

> You have 30 days from the day you receive this policy, certificate, or rider to review it and return it to the insurer if you decide not to keep it. You do not have to tell the insurer why you are returning it. If you decide not to keep it, simply return it to the insurer at its administrative office or return it to the agent or broker that you bought it from as long as you have not filed a claim. You must return the policy, certificate, or rider within 30 days after the day you first received it. The insurer will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate, or rider will be void as if it had never been issued.

Exclusions and Waiting Periods

The bill authorizes a pet insurer to issue a policy:

- That excludes coverage on the basis of one or more preexisting conditions with appropriate disclosure to the applicant or policyholder. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.
- That imposes waiting periods upon effectuation of the policy which do not exceed 30 days for illnesses, diseases or orthopedic conditions not resulting from an accident. A pet insurer may not issue policies that impose waiting periods for accidents.

A pet insurer that imposes a waiting period authorized in this section must waive the waiting period upon completion of a medical examination. Pet insurers may require that such examination be conducted by a licensed veterinarian after the purchase of the policy and the insurer will pay for the examination. Such an examination required by a pet insurer must be paid for by the policyholder, unless the policy specifies the pet insurer will pay for the examination.

A pet insurer may specify requirements for the medical examination and require documentation that such requirements were satisfied, provided the specifications do not unreasonably restrict the ability of the applicant or policyholder to waive the waiting periods.

A pet insurer may not require a medical examination by a veterinarian of the covered pet for the policyholder to renew the policy. If a pet insurer includes any prescriptive, wellness, or noninsurance benefits in the pet insurance policy, such benefits are made part of the policy and must conform to all applicable laws in the code.

Agent Training

The bill provides that pet insurers must ensure that its agents are trained in the following topics:
- Preexisting conditions and waiting periods.
- The differences between pet insurance and noninsurance wellness programs.
- Hereditary disorders, congenital anomalies or disorders, and chronic conditions and the way pet insurance policies address those conditions or disorders.
- Rating, underwriting, renewal, and other related administrative topics.

Rulemaking

The bill authorizes the commission to adopt rules to administer this section**.**

Section 4. Provides the act takes effect January 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Fees for agents (producers)

B. Private Sector Impact:

The increased transparency provided by the policy disclosures will provide consumers with greater information to use in comparing the costs of premiums and benefits of various pet insurance policies.

The purchase of a pet insurance may reduce the out of pocket costs a consumer incurs when a pet experiences an unexpected medical emergency.

Enactment of the bill will provide greater regulatory certainty for insurers that write such coverage in Florida.

C. Government Sector Impact:

The implementation of standard policy forms and disclosures will assist in streamlining the review process.

The OIR can implement the provisions of the bill using existing resources.[29]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends sections 624.604 and 626.9541 of the Florida Statutes.
This bill creates section 627.71545 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 6, 2024:
The CS:

- Revises the definition of the term, "property insurance," in the Florida Insurance Code to provide that it may include pet insurance;
- Transfers and adds provisions relating to prohibited acts of insurers and agents, relating to pet wellness programs sales practices, to Part IX, of ch. 626, F.S, Unfair Insurance Trade Practices;
- Transfers provisions relating to the regulation of insurers transacting pet insurance to Part X of ch. 627, F.S, Property Insurance Contracts;

[29] Office of Insurance Regulation, SB 1338 Bill Analysis (2024) (on file with Senate Banking and Insurance Committee staff).

- Revises the definition of veterinarian to comport with ch. 474, F.S., Veterinary Medical Practice; and
- Provides technical, clarifying changes.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/08/2024	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 624.604, Florida Statutes, is amended to read:

624.604 "Property insurance" defined.—"Property insurance" is insurance on real or personal property of every kind and of every interest therein, whether on land, water, or in the air, against loss or damage from any and all hazard or cause, and

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against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance may include pet insurance that provides coverage for accidents and for illnesses or diseases of pets. Property insurance may contain a provision for accidental death or injury as part of a multiple peril homeowner's policy. Such insurance, which is incidental to the property insurance, is not subject to the provisions of this code applicable to life or health insurance. Property insurance does not include title insurance, as defined in s. 624.608.

Section 2. Paragraph (hh) is added to subsection (1) of section 626.9541, Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(hh) *Sales practices for pet wellness programs.*—

1. A pet insurance agent may not market a wellness program as pet insurance.

2. If a wellness program is sold by a pet insurance agent:

a. The purchase of the wellness program may not be a prerequiste to the purchase of pet insurance;

b. The costs of the wellness program must be separate and identifiable from any pet insurance policy sold by the pet insurance agent;

c. The terms and conditions of the wellness program must be separate from any pet insurance policy sold by the agent;

d. The products or coverages available through the wellness

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program may not duplicate the products or coverages available through the pet insurance policy; and

e. The advertising of the wellness program must not be misleading.

Section 3. Section 627.71545, Florida Statutes, is created to read:

627.71545 Pet insurance; noninsurance wellness programs.—

(1) This section may be cited as the "Pet Insurance Act."

(2) The purpose of this section is to promote the public welfare by creating a comprehensive regulatory framework within which pet insurance may be sold in this state.

(3) This section applies to all of the following:

(a) Pet insurance policies that are issued to any resident of this state or that are sold, solicited, negotiated, or offered in this state.

(b) Pet insurance policies or certificates that are delivered or issued for delivery in the state.

(4)(a) This section may not be construed to prohibit or limit the types of exclusions pet insurers may use in their policies or to require pet insurers to include in such policies any of the limitations or exclusions specified in subsection (9).

(b) All other applicable provisions of the Florida Insurance Code apply to pet insurance, except that this section supersedes any general provisions of the Florida Insurance Code which otherwise apply to pet insurance.

(5)(a) As used in this section, the term:

1. "Chronic condition" means a condition that can be treated or managed, but not cured.

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2. "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, and that may cause or contribute to illness or disease.

3. "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

4. "Orthopedic" refers to a condition that affects the bones, skeletal muscle, cartilage, tendons, ligaments, or joints. Orthopedic conditions include, but are not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and cranial cruciate ligament rupture but do not include any cancer or any metabolic, hematopoietic, or autoimmune disease.

5. "Pet insurance" means an insurance policy that provides coverage for accidents and for illnesses and diseases of pets. Such insurance reimburses a policyholder for expenses associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by the veterinarian.

6. "Pet insurance policy" or "policy" includes pet insurance certificates.

7. "Preexisting condition" means a condition for which any of the following is true before the effective date or during a waiting period applicable to a pet insurance policy:

a. A veterinarian provided medical advice.

b. The pet received previous treatment.

c. Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for

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which a claim is being made.

A condition for which coverage is afforded on a policy is not deemed to be a preexisting condition on any renewal of the policy.

8. "Renewal" means the issuance and delivery at the end of an insurance policy period of a policy that supersedes the policy previously issued and delivered by the same pet insurer or affiliated pet insurer and that provides types and limits of coverage substantially similar to those contained in the policy being superseded.

9. "Veterinarian" means a health care practitioner who is licensed to engage in the practice of veterinary medicine in Florida under chapter 474.

10. "Waiting period" means the period of time specified in a pet insurance policy which is required to run before some or all of the coverage in the policy may begin. This period may not be applied to renewals of existing coverage.

11. "Wellness program" means a subscription or reimbursement-based program that is separate from an insurance policy and that provides goods and services to promote the general health, safety, or well-being of the covered pet. If the subscription or program includes language such as "undertakes to indemnify another," "pays a specified amount upon determinable contingencies," or "provides coverage for a fortuitous event," the subscription or program is transacting in the business of insurance and is subject to the Florida Insurance Code. This definition is not intended to classify a contract directly between a service provider and a pet owner which involves only

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the two parties as being the business of insurance, unless other indications of insurance also exist.

(b) If a pet insurer uses any of the terms defined in paragraph (a) in a pet insurance policy, the pet insurer must use the definition of each term as provided in paragraph (a) and must include each such definition in the policy. The pet insurer must also make such definitions available through a clear and conspicuous link on the main page of the website of the pet insurer or the pet insurer's program administrator.

(6)(a) A pet insurer transacting pet insurance must disclose the following to pet insurance applicants and policyholders:

1. Whether the policy excludes coverage due to any of the following:

a. A chronic condition;

b. A congenital anomaly or disorder;

c. A hereditary disorder; or

d. A preexisting condition.

2. If the policy includes any other exclusions not listed in subparagraph 1., the pet insurer must state the following in the disclosure: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

3. Any policy provision that limits coverage through a waiting period, a deductible, a coinsurance payment, or an annual or lifetime policy limit. Waiting periods and applicable requirements must be clearly and prominently disclosed to applicants before the policy purchase.

4. Whether the pet insurer reduces coverage or increases premium based on the policyholder's claim history, the age of

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the covered pet, or a change in the geographic location of the policyholder.

5. Whether the underwriting company differs from the brand name used to market and sell the pet insurance.

(b) Before issuing a pet insurance policy, a pet insurer shall, through a clear and conspicuous link on the main page of the pet insurer's or the pet insurer's program administrator's website, provide a summary description of the basis or formula for the pet insurer's determination of claim payments under the policy.

1. A pet insurer that uses a benefit schedule to determine claim payments under a pet insurance policy must clearly disclose both of the following:

a. The applicable benefit schedule in the policy.

b. All benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

2. A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

a. Include a usual and customary fee limitation provision in the policy which clearly describes the pet insurer's basis or formula for determining usual and customary fees and the manner in which that basis or formula is applied in calculating claim payments.

b. Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the

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main page of the pet insurer's or pet insurer's program administrator's website.

(c) If any medical examination of the pet by a veterinarian is required to effectuate coverage, the pet insurer must clearly and conspicuously disclose any requirement for the examination before the policy is purchased and must disclose that examination documentation may result in a preexisting condition exclusion.

(d) A pet insurer shall create a summary of all policy disclosures required in paragraphs (a), (b), and (c) in a separate document titled "Insurer Disclosure of Important Policy Provisions." The pet insurer shall post the document through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(e) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall provide the policyholder with a copy of the Insurer Disclosure of Important Policy Provisions document required under paragraph (d), in at least 12-point type. At such time, the pet insurer shall also include a written disclosure with all of the following:

1. Contact information for the Division of Consumer Services of the department, including a link and toll-free telephone number, for consumers to submit inquiries and complaints relating to pet insurance products regulated by the department or office.

2. The address and customer service telephone number of the pet insurance agent.

(f) The disclosures required in this subsection are in addition to any other disclosures required by the insurance code

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or rules prescribed by the commission.

(7) Unless the policyholder has filed a claim under the pet insurance policy, a pet insurance applicant or policyholder may examine and return the policy or rider to the pet insurer or pet insurance agent or broker within 30 days after the applicant or policyholder obtains the receipt and is entitled to the premium refunded if, after examining the policy or rider, he or she is not satisfied for any reason.

(8) A pet insurance policy and rider must have a notice prominently printed on or attached to the first page which includes specific instructions to accomplish a return, in type at least as large as any type appearing on the policy or rider contract and in substantially the following language:

You have 30 days from the day you receive this policy, certificate, or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep policy, certificate, or rider, simply return it to the company at its administrative office or return it to the insurance agent or broker who you bought it from as long as you have not filed a claim. You must return policy, certificate, or rider within 30 days after the day you first received it in order to receive a refund. The company must refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate, or rider

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will be void as if it had never been issued.

(9)(a) A pet insurer may issue a policy that excludes coverage on the basis of one or more preexisting conditions with appropriate written disclosure to the applicant or policyholder. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

(b)1. A pet insurer may issue a policy imposing a waiting period before the effective date of a new policy which does not exceed 30 days for illnesses or diseases or for orthopedic conditions not resulting from an accident. A pet insurer may not issue a policy imposing a waiting period for accidents.

2. A pet insurer issuing a policy that imposes a waiting period shall include a provision in its contract which allows the waiting period to be waived upon completion of a medical examination of the pet by a veterinarian. The pet insurer may require the examination to be conducted by a veterinarian after the purchase of the policy.

a. A medical examination required under this subparagraph must be paid for by the policyholder, unless the policy specifies that the pet insurer will pay for the examination.

b. A pet insurer may specify requirements for the examination and require documentation that the requirements have been satisfied, provided that the specifications do not unreasonably restrict the ability of the applicant or policyholder to waive the waiting period.

(c) A pet insurer may not require a medical examination of the covered pet for the policyholder to renew a policy.

(d) If a pet insurer includes any prescriptive, wellness, or noninsurance benefit in the policy form, the benefit is made part of the policy contract and must comply with all of the applicable provisions of the Florida Insurance Code.

(e) An applicant's eligibility to purchase a pet insurance policy may not be based on his or her participation, or lack of participation, in a separate wellness program.

(10)(a) Pet insurers must ensure that its agents are trained on the topics specified in paragraph (b) and that its agents have been appropriately trained on the coverages and conditions of its pet insurance products.

(b) The training required under this subsection must include information on all of the following topics:

1. Preexisting conditions and waiting periods.

2. The differences between pet insurance and noninsurance wellness programs.

3. Chronic conditions, congenital anomalies or disorders, and hereditary disorders and the way pet insurance policies address those conditions or disorders.

4. Rating, underwriting, renewal, and other related administrative topics.

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

Section 4. This act shall take effect January 1, 2025.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

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A bill to be entitled

An act relating to ; providing an effective date.

By Senator DiCeglie

18-00373-24 20241338__

A bill to be entitled

An act relating to pet insurance; creating ch. 644, F.S., to be entitled "Pet Insurance"; providing a short title; creating s. 644.001, F.S.; providing legislative purpose; providing applicability; providing construction; creating s. 644.002, F.S.; defining terms; requiring pet insurers to use certain terms as defined in this act and include such definitions in their policies and on their website or on their program administrator's website; creating s. 644.003, F.S.; requiring pet insurers to disclose certain information; requiring pet insurers to provide a certain summary description; requiring pet insurers who use a benefit schedule to disclose certain information; specifying requirements for pet insurers that determine claim payments based on usual and customary fees; specifying requirements if a medical examination by a licensed veterinarian is required to effectuate coverage; requiring pet insurers to provide policyholders with a summary of policy disclosures and additional disclosures at a specified time; specifying that certain disclosures are in addition to other specified disclosure requirements; authorizing a policyholder to return a pet insurance policy, certificate, or rider and have the full premium refunded under certain circumstances; requiring that pet insurance policies, certificates, and riders must contain a specified notice; creating s. 644.004, F.S.; authorizing a pet insurer to issue policies that

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exclude coverage on the basis of a preexisting condition under certain circumstances; specifying a burden of proof for pet insurers relating to preexisting conditions; authorizing pet insurers to issue policies that impose certain waiting periods for certain purposes; prohibiting pet insurers from issuing policies with waiting periods for accidents; requiring pet insurers to waive certain waiting periods upon completion of a medical examination; requiring that such waiver be explained in the policy; authorizing pet insurers to require that such examination be conducted by a licensed veterinarian; requiring that such examination be paid for by the policyholder under certain conditions; authorizing pet insurers to make certain specifications and require documentation relating to such examination; prohibiting pet insurers from requiring a medical examination to renew a pet insurance policy; requiring prescriptive, wellness, or noninsurance benefits to conform to certain laws and regulations under certain circumstances; creating s. 644.005, F.S.; prohibiting pet insurers and insurance producers from marketing a wellness program as pet insurance; specifying that coverages listed in an insurance policy are insurance; providing requirements for wellness programs sold by pet insurers or insurance producers; requiring pet insurers and insurance producers to disclose certain information; creating s. 644.006, F.S.; prohibiting insurance producers from selling, soliciting, or

negotiating a pet insurance product unless the producer is licensed and has completed certain training; requiring pet insurers to ensure their producers are trained; specifying requirements for such training; providing that training requirements of another state satisfy training requirements in this state under certain conditions; creating s. 644.007, F.S.; requiring the Financial Services Commission to adopt certain rules; specifying that the commission has certain powers of administration and enforcement; providing an effective date.

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

Section 1. Chapter 644, Florida Statutes, consisting of ss. 644.001-644.007, is created and entitled "Pet Insurance."

Section 2. This act may be cited as the "Pet Insurance Act."

Section 3. Section 644.001, Florida Statutes, is created to read:

644.001 Purpose and scope.—

(1) The purpose of this chapter is to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold in this state.

(2) This chapter applies to all of the following:

(a) Pet insurance policies that are issued to any resident of this state or that are sold, solicited, negotiated, or offered in this state.

(b) Pet insurance policies or certificates that are

delivered or issued for delivery in this state.

(3) All other applicable provisions of the insurance laws of this state continue to apply to pet insurance except that the specific provisions of this chapter supersede any general provisions of law which would otherwise be applicable to pet insurance.

(4) This chapter may not be construed to prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions specified in s. 644.003.

Section 4. Section 644.002, Florida Statutes, is created to read:

644.002 Definitions.—

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

(a) "Chronic condition" means a condition that can be treated or managed, but not cured.

(b) "Commission" means the Financial Services Commission.

(c) "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

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

(e) "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

(f) "Orthopedic" refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, or joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia,

intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.

(g) "Pet insurance" means a property insurance policy that provides coverage for accidents and illnesses of pets.

(h)1. "Preexisting condition" means any condition for which any of the following are true before the effective date of a pet insurance policy or during any waiting period:

a. A veterinarian provided medical advice.

b. The pet received treatment.

c. Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

2. A preexisting condition does not include a condition that was covered under a preceding policy period before the renewal of the policy so long as there was no break in the superseding policy period.

(i) "Renewal" means the issuing and delivering at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

(j) "Veterinarian" means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

(k) "Waiting period" means the period of time specified in a pet insurance policy which is required to transpire before

some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

(l) "Wellness program" means a subscription-based or reimbursement-based program that is separate from an insurance policy which provides goods and services to promote the general health, safety, or well-being of the pet.

(2) If a pet insurer uses any of the terms defined in this section in a pet insurance policy, the pet insurer must use the terms as they are defined in this section and include the definitions of those terms in the policy. The pet insurer shall also make the definitions of all of the terms used in its pet insurance policy which are defined in this section available through a clear and conspicuous link on the main page of the pet insurer's or the pet insurer's program administrator's website.

Section 5. Section 644.003, Florida Statutes, is created to read:

644.003 Required disclosures; right to return.—

(1) A pet insurer shall disclose all of the following to consumers:

(a)1. Whether the policy excludes coverage due to any of the following:

a. A preexisting condition.

b. A hereditary disorder.

c. A congenital anomaly or disorder.

d. A chronic condition.

2. If the policy includes any other exclusions not listed in subparagraph 1., the pet insurer must state the following in the disclosure: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

(b) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit. Waiting periods and the requirements applicable to them must be clearly and prominently disclosed to consumers before the policy purchase.

(c) Whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet, or a change in the geographic location of the insured.

(d) Whether the underwriting company differs from the brand name used to market and sell the product.

(2) Before issuing a pet insurance policy, a pet insurer shall provide, through a clear and conspicuous link on the main page of the pet insurer's website or the website of the insurer's program administrator, a summary description of the basis or formula for the pet insurer's determination of claim payments under the policy.

(3) A pet insurer that uses a benefit schedule to determine claim payments under a pet insurance policy must clearly disclose both of the following:

(a) The applicable benefit schedule in the policy.

(b) All benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(4) A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

(a) Include a usual and customary fee limitation provision in the policy which clearly describes the pet insurer's basis or formula for determining usual and customary fees and how that basis or formula is applied in calculating claim payments.

(b) Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(5) If any medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer must clearly and conspicuously disclose the required aspects of the examination before the policy is purchased and must disclose that examination documentation may result in a preexisting condition exclusion.

(6) A pet insurer shall include a summary of all policy disclosures required in subsections (1)-(5) in a separate document titled "Insurer Disclosure of Important Policy Provisions." The pet insurer shall post the document by way of a clear and conspicuous link on the main page of the pet insurer's or pet insurer's program administrator's website.

(7) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall provide the policyholder with a copy of the Insurer Disclosure of Important Policy Provisions document required under subsection (6) in at least 12-point type. At such time, the pet insurer shall also include a written disclosure with all of the following information:

(a) The department's mailing address, toll-free telephone number, and website.

(b) The address and customer service telephone number of the pet insurer or the insurance producer.

(c) If the policy was issued or delivered by an agent or a broker, a statement advising the policyholder to contact the agent or broker for assistance.

(8) The disclosures required in this section are in addition to any other disclosures required by law, rule, or regulation.

(9)(a) Unless a policyholder has filed a claim, the policyholder has the right to return the pet insurance policy, certificate, or rider to the insurer within 30 days after his or her receipt of the pet insurance policy, certificate, or rider and to have the full premium refunded if, after examination of the policy, certificate, or rider, the policyholder is not satisfied for any reason.

(b) Pet insurance policies, certificates, and riders must have a notice prominently printed on the first page or attached thereto which includes specific instructions to accomplish a return under paragraph (a). The notice must state, in substantially similar form, the following:

You have 30 days from the day you receive this policy, certificate, or rider to review it and return it to the insurer if you decide not to keep it. You do not have to tell the insurer why you are returning it. If you decide not to keep it, simply return it to the insurer at its administrative office or return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return

it within 30 days after the day you first received it. The insurer will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate, or rider will be void as if it had never been issued.

Section 6. Section 644.004, Florida Statutes, is created to read:

644.004 Policy restrictions.—

(1) A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer pursuant to s. 644.003. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

(2)(a) A pet insurer may issue policies that impose waiting periods upon effectuation of the policy which do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. A pet insurer may not issue policies that impose waiting periods for accidents.

(b) A pet insurer that imposes a waiting period permitted in paragraph (a) shall waive the waiting period upon completion of a medical examination. The pet insurer shall include a provision in its policy which explains such waiver. Pet insurers may require that such examination be conducted by a licensed veterinarian after the purchase of the policy.

(c) The policyholder must pay for the medical examination under paragraph (b) unless the policy specifies that the pet

insurer will pay for the examination.

(d) A pet insurer may specify elements to be included as part of the examination under paragraph (b) and require documentation that such elements were included, provided the specifications do not unreasonably restrict the ability to waive the waiting periods as provided in paragraph (b).

(3) A pet insurer may not require a medical examination by a veterinarian of the covered pet for the insured to renew the policy.

(4) If a pet insurer includes any prescriptive, wellness, or noninsurance benefits in the pet insurance policy, such benefits are made part of the policy and must conform to all applicable laws and regulations in the insurance code.

Section 7. Section 644.005, Florida Statutes, is created to read:

644.005 Sales practices for wellness programs.—

(1) A pet insurer or an insurance producer may not market a wellness program as pet insurance. Coverages included in the pet insurance policy described as wellness benefits are insurance.

(2) If a wellness program is sold by a pet insurer or an insurance producer, all of the following conditions must be met:

(a) The purchase of the wellness program may not be a requirement for the purchase of pet insurance.

(b) The costs of the wellness program must be separate and identifiable from any pet insurance policy sold by a pet insurer or an insurance producer.

(c) The terms and conditions for the wellness program must be separate from any pet insurance policy sold by a pet insurer or an insurance producer.

(d) The products or coverages available through the wellness program may not duplicate products or coverages available through the pet insurance policy.

(e) The advertising of the wellness program may not be misleading and must be in accordance with subsection (3).

(3) A pet insurer or an insurance producer shall clearly disclose all of the following to consumers, printed in 12-point boldface type:

(a) That wellness programs are not insurance.

(b) The address and customer service telephone number of the pet insurer or producer.

(c) The department's mailing address, toll-free telephone number, and website address.

Section 8. Section 644.006, Florida Statutes, is created to read:

644.006 Insurance producer training.—

(1) An insurance producer may not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in subsection (3).

(2) Insurers shall ensure that its producers are trained under subsection (3) and that its producers have been appropriately trained on the coverages and conditions of its pet insurance products.

(3) The training required under this section must include information on all of the following topics:

(a) Preexisting conditions and waiting periods.

(b) The differences between pet insurance and noninsurance wellness programs.

(c) Hereditary disorders, congenital anomalies or disorders, and chronic conditions and how pet insurance policies interact with those conditions or disorders.

(d) Rating, underwriting, renewal, and other related administrative topics.

(4) If an insurance producer satisfies the training requirements of another state which are substantially similar to the provisions of subsection (3), the producer is deemed to have satisfied the training requirements in this state.

Section 9. Section 644.007, Florida Statutes, is created to read:

644.007 Rulemaking authority and enforcement.—The commission shall adopt rules to administer this chapter and has the same powers of administration and enforcement of this chapter as it has with respect to casualty or surety insurers in general under the Florida Insurance Code.

Section 10. This act shall take effect January 1, 2025.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

B&I
Committee

1338
Bill Number or Topic

Amendment Barcode (if applicable)

Name DONOVAN BROWN

Phone 850.815.6010

Address 113 E COLLEGE AVE
Street

Email

TLH FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
NAPHIA (NA-FEE-UH)
NORTH AMERICAN PET HEALTH INSURANCE ASSOCIATION

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

2024 AGENCY LEGISLATIVE BILL ANALYSIS
Office of Insurance Regulation

BILL INFORMATION	
BILL NUMBER:	SB 1338
BILL TITLE:	Pet Insurance
BILL SPONSOR:	DiCeglie
EFFECTIVE DATE:	1/1/2025

COMMITTEES OF REFERENCE
1) Banking and Insurance
2) Appropriations Committee on Agriculture, Environment, and General Government
3) Fiscal Policy
4)
5)

CURRENT COMMITTEE
Banking and Insurance

SIMILAR BILLS	
BILL NUMBER:	HB 1465
SPONSOR:	Tuck

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	
LEAD AGENCY ANALYST:	
ADDITIONAL ANALYST(S):	
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

SB 1338 creates chapter 644, F.S, providing a comprehensive legal framework for regulating pet insurance policies in this state. This bill is based on Model law 633, issued by the National Association of Insurance Commissioners (NAIC) in 2022. The effective date for this bill is January 1, 2025.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Currently, the state has no specific insurance regulations regarding pet insurance.

The NAIC published a white paper, titled “A Regulator’s Guide to Pet Insurance,” in 2017. It noted the rapid increase in the prevalence of pet insurance since the first such policy was sold in the U.S. in 1982. The paper noted that in 2017 the premiums for pet insurance totaled $1.03 billion dollars and those policies covered over 1.8 million pets. In 2021 annual premiums were up to $2.8 billion and covered 4.41 million pets.

The paper noted the lack of regulation regarding rates and policy limitation disclosures, as well as confusion in the marketplace as to what constituted pet insurance as opposed to a wellness program. In addition, the property insurance laws being used to administer pet insurance did not have clear guidance on concepts such a preexisting conditions, chronic conditions, and other items that are usually associated with health insurance policies, rather than property insurance policies.

The NAIC followed up on its white paper by publishing Model Law 633, the Pet Insurance Model Act in 2022.

2. EFFECT OF THE BILL:

Administrative Provisions

This bill creates Chapter 644, providing a comprehensive legal framework for regulating pet insurance policies in this state by adopting the provisions of the NAIC Pet Insurance Model Act of 2022.

Sections 1 through 4: Section 1 of the bill creates chapter 644, F.S. Section 2 states that this legislation can be cited as the “Pet Insurance Act.” Section 3 creates section 644.001, F.S., which specifies the scope and purpose of this Chapter. Section 4 creates section 644.002, F.S., providing definitions.

Sections 9 and 10: Section 9 provides rulemaking authority to implement this chapter and section 10 provides that this act shall take effect on January 1, 2025.

Consumer Protection Provisions

This bill includes several measures to ensure consumer protection, requiring disclosures regarding waiting periods, policy limits, conditions, and benefit schedules, as well as providing consumer protections related to policy renewals, wellness programs, and insurance producers.

Section 5: Creates section 644.003, F.S., regarding the disclosures that must be provided to the policyholder, including requirements for information to be published on the insurer’s website. This section also specifies that the policyholder can return the policy within 30 days for a full refund of the premium paid, provided no claim has been filed under said policy.

Section 6: Creates section 644.004, F.S., regarding policy restrictions. It allows exclusions for preexisting conditions, and a waiting period for coverage for illness or orthopedic conditions, other than those caused by an accident, during the first 30 days of the policy term. The bill requires that the insurer pay for any required initial physical of the animal unless otherwise specified in the policy and allows the insurer to specify the elements included in that examination, provided they do not restrict the ability to waive the waiting period. A medical examination may not be required for renewal of a pet insurance policy, and if any prescription, wellness, or noninsurance benefits are included in the policy, they must be part of the policy and conform to the insurance code.

Section 7: The legislation defines “wellness programs” as programs that “provide goods and services to promote the general health, safety, and well-being of the pet” but does not provide actual pet insurance. This legislation creates section 644.005, F.S., which provides that a wellness program may not be marketed as pet insurance.

Section 8: Specifically requires that an insurance producer must be properly licensed and receive specific information regarding pet insurance before they may sell, solicit, or negotiate a pet insurance policy.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	The creation of a new rule chapter will require both a review of current rules and possibly the creation of new rules to implement the provisions of this Chapter. The bill does include the rulemaking authority necessary.
What is the expected impact to the agency’s core mission?	
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	
Provide a summary of the proponents’ and opponents’ positions:	

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL?

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	

Expenditures:	
Does the legislation increase local taxes or fees?	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	
Expenditures:	
Does the legislation contain a State Government appropriation?	
If yes, was this appropriated last year?	

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	
Expenditures:	
Other:	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	
Does the bill decrease taxes, fees or fines?	
What is the impact of the increase or decrease?	
Bill Section Number:	

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support,	Yes, pet insurance will have to be added to OIR's systems, however that impact will be at one-time and can be absorbed by OIR resources.

licensing software, data storage, etc.)?	
If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	
If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

- This bill would help reduce the amount of time spent on pet insurance filings by providing guidance and a baseline for review of pet insurance policies.
- This bill creates a new chapter but does not specifically add this new chapter into the Insurance Code. A change to s.624.01, F.S., is recommended. The sponsor may also want to include Chapter 647 in any amendment to s. 624.01, F.S., so that statute would read: Short title. –Chapter 624-632, 634, 635, 636, 641, 642, 644, 647, 648, and 651 constitute the "Florida Insurance Code." (When Chapter 647 on Travel Insurance was added the Short Title was not amended.)
- As an alternative to creating a new chapter, the pet insurance provisions could be added to Part II of Chapter 627, The Insurance Contract or by creating Part XXIII in Chapter 627. Pet Insurance (ss. 627.9951-627.9958).
- The bill does not address how violations will be handled, though there is language in the model law. The sponsor could consider including that language in a new section, such as "Section 644.007 Violations".
- If section 624.01 is amended to include chapter 644, a violation of this act would subject the party committing the violation to applicable penalties under the Florida Insurance Code.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1338
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/06/2024 adopted 1 DiCeglie					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
VA		Torres						
X		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
11	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1366
INTRODUCER:	Banking and Insurance Committee and Senator DiCeglie
SUBJECT:	My Safe Florida Condominium Pilot Program
DATE:	February 8, 2024 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1366 creates the My Safe Florida Condominium Pilot Program (Program) within the Department of Financial Services (DFS), to provide hurricane mitigation inspections and hurricane mitigation grants to eligible condominium associations. Implementation of the Program is subject to annual legislative appropriations. Under the Program, the DFS must provide fiscal accountability, contract management, and strategic leadership for the Program.

The bill provides to condominium associations with 15 miles of the coastline a program similar to that of the My Safe Florida Home Program for owners of site-built, single-family, residential properties in regards to requirements for participation, hurricane mitigation inspectors and inspections, eligibility for mitigation grants, contract management by DFS, and required annual reports.

Unless funded, the bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2024

II. Present Situation:

My Safe Florida Home Program

Background

In 2006, the Legislature created the My Safe Florida Home (MSFH) Program within the Department of Financial Services (DFS).[1] The MSFH Program was created with the intent to provide trained and certified inspectors to perform mitigation inspections for owners of site-built, single-family, residential properties (mitigation inspections), and mitigation grants to eligible applicants, subject to the availability of funds.[2] The MSFH Program was to "develop and implement a comprehensive and coordinated approach for hurricane damage mitigation…"[3] From its inception to January 30, 2009, the MSFH Program received approximately 425,193 applications, performed more than 391,000 inspections and awarded 39,000 grants. From July 2007 through January 2009, MSFH Program expenditures totaled approximately $151.9 million.[4] Funding for the MSFH Program ceased on June 30, 2009.

2022 Renewal and Funding of the MSFH Program

In May 2022, during Special Session 2022-D, the Legislature reestablished the MSFH Program within the DFS to provide financial incentives for Florida residential property owners to obtain free home inspections which identify mitigation measures and provide mitigation grants to retrofit such properties, thereby reducing their vulnerability to hurricane damage and helping decrease the cost of residential property insurance.[5]

Hurricane Mitigation Inspections

The MSFH Program provides licensed inspectors to perform inspections for owners of site-built, single-family, residential properties, for which a homestead exemption has been granted, to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. A townhouse as defined in s. 481.203, F.S.,6 for which a homestead exemption has been granted, may qualify to receive a mitigation inspection to determine if opening protection7 mitigation would provide improvements to mitigate hurricane damage. The mitigation inspections must include, at a minimum:

- A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage;
- A range of cost estimates regarding the recommended mitigation improvements; and

[1] The Legislature initially established the MSFH Program as the Florida Comprehensive Hurricane Damage Mitigation Program (ch. 2006-12, L.O.F.) however, the name was subsequently changed in 2007 (ch. 2007-126, L.O.F.).
[2] Section 215.5586, F.S.
[3] *Id*.
[4] Florida Auditor General, *Department of Financial Services, My Safe Florida Home Program, Operational Audit Report No. 2010-074* (Jan. 1010), *available at* https://flauditor.gov (last visited February 1, 2024).
[5] Section 3, ch. 2022-268, L.O.F.
[6] "Townhouse" generally means "a single-family dwelling unit not exceeding three stories in height which is constructed in a series or group of attached units with property lines separating such units." Section 481.203(16), F.S.
[7] Opening protection includes windows, exterior doors, and garage doors. See s. 215.5586(2)(e), F.S.

- Information regarding estimated premium discounts, correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.[8]

The DFS is authorized to contract with "wind certification entities" as vendors to provide such inspections. Each wind certification entity must, at a minimum, meet the following requirements:

- Use hurricane mitigation inspectors who are licensed or certified as:
  - A building inspector under s. 468.607, F.S.;
  - A general, building, or residential contractor under s. 489.111, F.S.;
  - A professional engineer under s. 471.015, F.S.;
  - A professional architect under s. 481.213, F.S.; or
  - A home inspector under s. 468.8314 and who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board, which training must include hurricane mitigation techniques, compliance with the uniform mitigation verification form, and completion of a proficiency exam.
- Use hurricane mitigation inspectors who have undergone drug testing and background screening.
- Provide a quality assurance program that includes a reinspection component.[9]

Hurricane Mitigation Grants

The homeowner eligibility requirements for the mitigation grants are:

- The homeowner must have been granted a homestead exemption on the home;
- The home must be a dwelling with an insured value of $700,000 or less. Low-income homeowners are exempt from this requirement;
- The home must have undergone an acceptable hurricane mitigation inspection;
- The building permit for the initial construction of the home must have been made before January 1, 2008; and
- The homeowner must agree to make the home available for inspection upon completion of the mitigation project.[10]

MSFH Program grants must be matched on the basis of one dollar provided by the applicant for two dollars provided by the state, up to a maximum state contribution of $10,000 toward the actual cost of the mitigation project.[11] Low-income homeowners may receive up to $10,000 in grant funds without providing matching dollars.[12]

Grants may be used for the following improvements recommended by a hurricane mitigation inspection:

- Opening protection.
- Exterior doors, including garage doors.
- Reinforcing roof-to-wall connections.
- Improving the strength of roof-deck attachments.

[8] Section 215.5586(1)(b), F.S.
[9] Section 215.5586(1)(c), F.S.
[10] Section 215.5586(2)(a), F.S.
[11] Section 215.5586(2)(b), F.S.
[12] Section 215.5586(2)(h), F.S.

- Secondary water barrier for roof.

Grants for townhouses may only be used for opening protection.

Condominiums

A condominium is a "form of ownership of real property created under ch. 718, F.S,"[13] the "Condominium Act." Condominium unit owners are in a unique legal position because they are exclusive owners of property within a community, joint owners of community common elements, and members of the condominium association.[14] For unit owners, membership in the association is an unalienable right and required condition of unit ownership.[15] There are approximately 1,529,764 condominium units in Florida operated by 27,588 associations.[16]

A condominium association is administered by a board of directors referred to as a "board of administration."[17] The board of administration is comprised of individual unit owners elected by the members of a community to manage community affairs and represent the interests of the association. Association board members must enforce a community's governing documents and are responsible for maintaining a condominium's common elements which are owned in undivided shares by unit owners.[18]

A condominium association is required to use its best efforts to maintain insurance for the association, the association property, the common elements, and the condominium property.[19] Insurance coverage for the association must insure the condominium property as originally installed and all alterations or additions made to the condominium property.[20] Any portion of the condominium property that must be insured by the association against property loss which is damaged by an insurable event, must be reconstructed, repaired, or replaced as necessary by the association as a common expense to the association.[21]

III. Effect of Proposed Changes:

Section 1 creates s. 215.5587, F.S., to create the My Safe Florida Condominium Pilot Program (Program) within the Department of Financial Services (DFS). The bill provides to condominium associations within the prescribed service area a program similar to that of the MSFH Program in regards to requirements for participation, hurricane mitigation inspectors and inspections, eligibility for mitigation grants, contract management by DFS, and required annual reports. Implementation of the Program is subject to annual legislative appropriations and is intended to

[13] Section 718.103(11), F.S.
[14] *See* s. 718.103, F.S., for the terms used in the Condominium Act.
[15] *Id.*
[16] Report of the Florida Bar RPPTL Condominium Law and Policy Life Safety Advisory Task Force (Task Force Report), p. 4, *available at:* https://www-media.floridabar.org/uploads/2021/10/Condominium-Law-and-Policy-Life-Safety-Advisory-Task-Force-Report.pdf (last visited February 1, 2024).
[17] Section 718.103(4), F.S.
[18] Section 718.103(2), F.S.
[19] Section 718.111(11), F.S.
[20] Section 718.111(11)(f), F.S.
[21] Section 718.111(11)(j), F.S.

provide licensed inspectors to perform inspections for and grants to eligible associations as funding allows.

The bill limits the Program to associations located in the "service area." The "service area" is the area of the state within 15 miles inward of a coastline as defined in s. 376.031.[22] The bill provides that the terms "association,"[23] "board of administration,"[24] "condominium,"[25] "unit,"[26] and "unit owner"[27] have the same meaning as those terms are defined in s. 718.103, F.S. The bill provides additional definitions, as follows:

- "Association property," means property, whether real or personal, which is owned or leased by, or dedicated by a recorded plat to, the association for the use and benefit of its members and which is located in the service area.
- "Condominium property," means the lands, leaseholds, and personal property that are subject to condominium ownership, whether or not contiguous, and all improvements thereon and all easements and rights appurtenant thereto intended for use in connection with the condominium and that are located in the service area.
- "Property" means association property and condominium property, as applicable, located in the service area.
- "Rebuild" means property under construction to replace a structure that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority.

In order for a condominium association to apply for an inspection or a grant under the Program, the association must receive approval by a majority vote of the board of administration or a majority vote of the total voting interests of the association. In order to apply for a grant the association must also receive approval by a unanimous vote of all unit owners within the structure or building that is the subject of the mitigation grant.

Hurricane Mitigation Inspections

Inspections of the property to determine the mitigation measures that are needed, the insurance premium discounts that may be available, and the improvements to existing properties of the association that are needed to reduce a property's vulnerability to hurricane damage must be performed by licensed inspectors. The DFS must contract with wind certification entities to provide the inspections. Eligible wind certification entities must, at a minimum:

- Use inspectors who are licensed or certified as:

[22] "'Coastline' means the line of mean low water along the portion of the coast that is in direct contact with the open sea and the line marking the seaward limit of inland waters, as determined under the Convention on Territorial Seas and the Contiguous Zone, 15 U.S.T. (Pt. 2) 1606." Section 376.031(4), F.S.

[23] "Association" means, in addition to any entity responsible for the operation of common elements owned in undivided shares by unit owners, any entity which operates or maintains other real property in which unit owners have use rights, where membership in the entity is composed exclusively of unit owners or their elected or appointed representatives and is a required condition of unit ownership. Section 718.103(3), F.S.

[24] "Board of administration" or "board" means the board of directors or other representative body which is responsible for administration of the association. Section 718.103(5), F.S.

[25] "Condominium" means that form of ownership of real property created pursuant to this chapter, which is comprised entirely of units that may be owned by one or more persons, and in which there is, appurtenant to each unit, an undivided share in common elements. Section 718.103(12), F.S.

[26] "Unit" means a part of the condominium property which is subject to exclusive ownership. A unit may be in improvements, land, or land and improvements together, as specified in the declaration. Section 718.103(29), F.S.

[27] "Unit owner" or "owner of a unit" means a record owner of legal title to a condominium parcel. Section 718.103(30), F.S.

  - A building inspector under s. 468.607;
  - A general, building, or residential contractor under s. 489.111;
  - A professional engineer under s. 471.015;
  - A professional architect under s. 481.213; or
  - A home inspector under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board, which must include hurricane mitigation techniques, compliance with the uniform mitigation verification form, and completion of a proficiency exam.
- Use inspectors who have undergone drug testing and a background screening that includes submission and processing of fingerprints.
- Provide a quality assurance program, including a reinspection component.

Such inspections must, at a minimum, include:
- An inspection of the property, and a report that summarizes the results and identifies recommended improvements the association may take to mitigate hurricane damage.
- A range of cost estimates regarding the recommended mitigation improvements.
- Information regarding estimated insurance premium discounts.

An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury by the president of the board of administration that the association has submitted only a single application for each property that the association operates or maintains. An association may apply for and receive an inspection without also applying for a grant.

Hurricane Mitigation Grants

Financial grants may be used to encourage associations to retrofit the property the association operates and maintains in order to make such property less vulnerable to hurricane damage. An application for a grant must:
- Contain a signed or electronically verified statement made under penalty of perjury by the president of the board of administration that the association has submitted only a single application for each property that the association operates or maintains.
- Include a notarized statement from the president of the board of administration containing the name and license number of the contractor it intends to use for the mitigation project.
- Include a notarized statement from the president of the board of administration which commits to the DFS that the association will complete the mitigation improvements. If the grant will be used to improve units, the application must also include an acknowledged statement from each unit owner who is required to provide approval for a grant.

An association may select its own contractor for the mitigation project so long as the contractor meets all qualification, certification, or licensing requirements in general law. A mitigation project must be performed by a properly licensed contractor who has secured all required local permits necessary for the project. The DFS must electronically verify that the contractor's state license number is accurate and up to date before approving a grant application.

All grants must be matched on the basis of $1 provided by the association for $2 provided by the state up to a maximum contribution as provided in the General Appropriations Act. An association awarded a grant must complete the entire mitigation project in order to receive the

final grant award and must agree to make the property available for a final inspection once the mitigation project is finished. The association must submit a request to the DFS for a final inspection, or request an extension of time, within 1 year after receiving grant approval; otherwise the application is deemed abandoned and the grant money reverts back to the DFS.

When recommended by a hurricane mitigation inspection report, grants may be used for the following improvements:

- Opening protection.
- Exterior doors, including garage doors.
- Reinforcing roof-to-wall connections.
- Improving the strength of roof-deck attachments.
- Secondary water barrier for roof.

Grants may be used for a previously inspected existing structure on the property or for a rebuild. If improvements to protect the property which complied with the current applicable building code at the time have been previously installed, the association must use a mitigation grant to install improvements that do both of the following:

- Comply with or exceed the applicable building code in effect at the time the association applied for the grant.
- Provide more protection than the improvements that the association previously installed.

The association may not use a mitigation grant to:

- Install the same type of improvements that were previously installed; or
- Pay a deductible for a pending insurance claim for damage that is part of the property for which grant funds are being received.

The DFS must develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility. The DFS may contract for grant management, inspection services, contractor services, information technology, educational outreach, and auditing services. Such contracts are considered direct costs of the Program and are not subject to administrative cost limits. Such contracts must be with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and must ensure the highest accountability for use of state funds.

The DFS is required to implement a quality assurance and reinspection program that determines whether initial inspections and mitigation improvements are completed in a manner consistent with the intent of the Program. The DFS may use a valid random sampling in order to perform the quality assurance portion of the Program.

By February 1 of each year, the DFS must submit a report to the President of the Senate and the Speaker of the House of Representatives on the activities of the Program and the use of state funds. The report must include:

- The number of inspections requested.
- The number of inspections performed.

- The number of grant applications received.
- The number of grants approved and the monetary value of each grant.
- The estimated average annual amount of insurance premium discounts each association received and the total estimated annual amount of insurance premium discounts received by all associations participating in the Program.
- The estimated average annual amount of insurance premium discounts each unit owner received as a result of the improvements to the building or structure.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

If funded, the Program will provide opportunities for certain condominium associations to receive mitigation credits or premium discounts under their property insurance policies and be less exposed to risk. Hurricane mitigation inspectors and contractors may also see an increase in activity.

For mitigation inspectors, the total fiscal impact for a state and national criminal history record check is $37.25. Of this total amount, the cost for the national portion of the criminal history record check is $13.25 and the cost for the state portion is $24. Vendors performing fingerprint scans may assess additional processing fees.

C. Government Sector Impact:

Unless funded, the bill has no fiscal impact on state or local governments.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Any appropriation used to fund the Program will need to include significant direction to the DFS regarding administration of the Program in proviso language. For instance, the bill does not establish a maximum amount for a grant to a condominium association.

VIII. Statutes Affected:

This bill creates the following section of the Florida Statutes: 215.5587.

IX. Additional Information:

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

CS by Banking and Insurance Committee on February 6, 2024:
The committee substitute:

- Limits the application of the Program to the area of the state within 15 miles inward of the coastline; and
- Clarifies the fingerprinting requirement to comport with a recommendation by FDLE.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/08/2024	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 67 - 150
and insert:
(b) "Association property" means property, whether real or personal, which is owned or leased by, or dedicated by a recorded plat to, the association for the use and benefit of its members and which is located in the service area.
(c) "Board of administration" has the same meaning as in s. 718.103.

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(d) "Condominium" has the same meaning as in s. 718.103.

(e) "Condominium property" means the lands, leaseholds, and personal property that are subject to condominium ownership, whether or not contiguous, and all improvements thereon and all easements and rights appurtenant thereto intended for use in connection with the condominium and that are located in the service area.

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

(g) "Property" means association property and condominium property, as applicable, located in the service area.

(h) "Rebuild" means property under construction to replace a structure that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority.

(i) "Service area" means the area of the state within 15 miles inward of a coastline as defined in s. 376.031.

(j) "Unit" has the same meaning as in s. 718.103.

(k) "Unit owner" has the same meaning as in s. 718.103.

(2) PARTICIPATION.—

(a) In order to apply for an inspection under subsection (4) or a grant under subsection (5) for association property or condominium property, an association must receive approval by a majority vote of the board of administration or a majority vote of the total voting interests of the association to participate in the pilot program.

(b) In order to apply for a grant under subsection (5) which improves one or more units within a condominium, an association must receive both of the following:

1. Approval by a majority vote of the board of

administration or a majority vote of the total voting interests of the association to participate in a mitigation inspection.

2. A unanimous vote of all unit owners within the structure or building that is the subject of the mitigation grant.

(c) A unit owner may participate in the pilot program through a mitigation grant awarded to the association but may not participate individually in the pilot program.

(d) The votes required under this subsection may take place at the annual budget meeting of the association or at a unit owner meeting called for the purpose of taking such vote. Before a vote of the unit owners may be taken, the association must provide to the unit owners a clear disclosure of the pilot program on a form created by the department. The president and the treasurer of the board of administration must sign the disclosure form indicating that a copy of the form was provided to each unit owner of the association. The signed disclosure form and the minutes from the meeting at which the unit owners voted to participate in the pilot program must be maintained as part of the official records of the association. Within 14 days after an affirmative vote to participate in the pilot program, the association must provide written notice in the same manner as required under s. 718.112(2)(d) to all unit owners of the decision to participate in the pilot program.

(3) HURRICANE MITIGATION INSPECTORS.—

(a) Licensed inspectors must be used to provide inspections of the property to determine the mitigation measures that are needed, the insurance premium discounts that may be available to the association, and the improvements to existing properties of the association that are needed to reduce a property's

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vulnerability to hurricane damage.

(b) The department shall contract with wind certification entities to provide hurricane mitigation inspections. To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity must, at a minimum, meet all of the following requirements:

1. Use hurricane mitigation inspectors who are licensed or certified as:

a. A building inspector under s. 468.607;

b. A general, building, or residential contractor under s. 489.111;

c. A professional engineer under s. 471.015;

d. A professional architect under s. 481.213; or

e. A home inspector under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board, which must include hurricane mitigation techniques, compliance with the uniform mitigation verification form, and completion of a proficiency exam.

2. Use hurricane mitigation inspectors who have undergone drug testing and a background screening. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a full set of fingerprints to the department or to a vendor, an entity, or an agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

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Fees for state and federal fingerprint processing shall be paid by the applicant. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e). The results

By Senator DiCeglie

18-00907A-24 20241366__

A bill to be entitled

An act relating to the My Safe Florida Condominium Pilot Program; creating s. 215.5587, F.S.; establishing the My Safe Florida Condominium Pilot Program within the Department of Financial Services; providing legislative intent; defining terms; providing requirements for associations and unit owners to participate in the pilot program; providing voting requirements; requiring the department to contract with specified entities for certain inspections; providing requirements for such entities; authorizing the department to conduct criminal record checks of certain inspectors; requiring inspectors to submit fingerprints and processing fees to the department; providing requirements for hurricane mitigation inspectors and inspections; requiring that applications for inspections and grants include specified statements; authorizing an association to receive an inspection without applying for a mitigation grant; providing mitigation grants for a specified purpose; providing requirements for an association receiving a mitigation grant; authorizing an association to select its own contractor if such contractor meets certain requirements; requiring the department to electronically verify a contractor's state license; requiring the association to complete construction to receive the final grant award; requiring the association to make the property available for final inspection once the project is

18-00907A-24 20241366__

completed; requiring that such construction be completed and that the association must submit a request for a final inspection within a specified timeframe; requiring that mitigation grants be matched by the association; providing a maximum state contribution based on the General Appropriations Act; providing requirements for mitigation projects; providing how mitigation grants may be used; requiring the department to develop a specified process to ensure efficiency; authorizing the department to contract for certain services; providing requirements for such contracts; requiring the department to implement a quality assurance and reinspection program; requiring the department to submit to the Legislature an annual report with specified information; providing an effective date.

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

Section 1. Section 215.5587, Florida Statutes, is created to read:

215.5587 My Safe Florida Condominium Pilot Program.—There is established within the Department of Financial Services the My Safe Florida Condominium Pilot Program to be implemented pursuant to appropriations. The department shall provide fiscal accountability, contract management, and strategic leadership for the pilot program, consistent with this section. This section does not create an entitlement for associations or unit owners or obligate the state in any way to fund the inspection

or retrofitting of condominiums in the state. Implementation of this pilot program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Condominium Pilot Program provide licensed inspectors to perform inspections for and grants to eligible associations as funding allows.

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

(a) "Association" has the same meaning as in s. 718.103.

(b) "Association property" has the same meaning as in s. 718.103.

(c) "Board of administration" has the same meaning as in s. 718.103.

(d) "Condominium" has the same meaning as in s. 718.103.

(e) "Condominium property" has the same meaning as in s. 718.103.

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

(g) "Property" means association property and condominium property, as applicable.

(h) "Rebuild" means property under construction to replace a structure that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority.

(i) "Unit" has the same meaning as in s. 718.103.

(j) "Unit owner" has the same meaning as in s. 718.103.

(2) PARTICIPATION.—

(a) In order to apply for an inspection under subsection (4) or a grant under subsection (5) for association property or condominium property, an association must receive approval by a majority vote of the board of administration or a majority vote

of the total voting interests of the association to participate in the pilot program.

(b) In order to apply for a grant under subsection (5) which improves one or more units within a condominium, an association must receive both of the following:

1. Approval by a majority vote of the board of administration or a majority vote of the total voting interests of the association to participate in a mitigation inspection.

2. A unanimous vote of all unit owners within the structure or building that is the subject of the mitigation grant.

(c) A unit owner may participate in the pilot program through a mitigation grant awarded to the association but may not participate individually in the pilot program.

(d) The votes required under this subsection may take place at the annual budget meeting of the association or at a unit owner meeting called for the purpose of taking such vote. Before a vote of the unit owners may be taken, the association must provide to the unit owners a clear disclosure of the pilot program on a form created by the department. The president and the treasurer of the board of administration must sign the disclosure form indicating that a copy of the form was provided to each unit owner of the association. The signed disclosure form and the minutes from the meeting at which the unit owners voted to participate in the pilot program must be maintained as part of the official records of the association. Within 14 days after an affirmative vote to participate in the pilot program, the association must provide written notice in the same manner as required under s. 718.112(2)(d) to all unit owners of the decision to participate in the pilot program.

(3) HURRICANE MITIGATION INSPECTORS.—

(a) Licensed inspectors shall provide inspections of the property to determine the mitigation measures that are needed, the insurance premium discounts that may be available to the association, and the improvements to existing properties of the association that are needed to reduce a property's vulnerability to hurricane damage.

(b) The department shall contract with wind certification entities to provide hurricane mitigation inspections. To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity must, at a minimum, meet all of the following requirements:

1. Use hurricane mitigation inspectors who are licensed or certified as:

a. A building inspector under s. 468.607;

b. A general, building, or residential contractor under s. 489.111;

c. A professional engineer under s. 471.015;

d. A professional architect under s. 481.213; or

e. A home inspector under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board, which must include hurricane mitigation techniques, compliance with the uniform mitigation verification form, and completion of a proficiency exam.

2. Use hurricane mitigation inspectors who have undergone drug testing and a background screening. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a set of

fingerprints to the department for state and national criminal history checks and must pay the fingerprint processing fee set forth in s. 624.501. The fingerprints must be sent by the department to the Department of Law Enforcement and forwarded to the Federal Bureau of Investigation for processing. The results must be returned to the department for screening. The fingerprints must be taken by a law enforcement agency, designated examination center, or other department-approved entity.

3. Provide a quality assurance program, including a reinspection component.

(4) HURRICANE MITIGATION INSPECTIONS.—

(a) The inspections provided to an association under this section must, at a minimum, include all of the following:

1. An inspection of the property, and a report that summarizes the results and identifies recommended improvements the association may take to mitigate hurricane damage.

2. A range of cost estimates regarding the recommended mitigation improvements.

3. Information regarding estimated insurance premium discounts, correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

(b) An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury by the president of the board of administration that the association has submitted only a single application for each property that the association operates or maintains.

(c) An association may apply for and receive an inspection

without also applying for a grant under subsection (5).

(5) MITIGATION GRANTS.—Financial grants may be used to encourage associations to retrofit the property the association operates and maintains in order to make such property less vulnerable to hurricane damage.

(a) An application for a mitigation grant must:

1. Contain a signed or electronically verified statement made under penalty of perjury by the president of the board of administration that the association has submitted only a single application for each property that the association operates or maintains.

2. Include a notarized statement from the president of the board of administration containing the name and license number of the contractor the association intends to use for the mitigation project.

3. Include a notarized statement from the president of the board of administration which commits to the department that the association will complete the mitigation improvements. If the grant will be used to improve units, the application must also include an acknowledged statement from each unit owner who is required to provide approval for a grant under paragraph (2)(b).

(b) An association may select its own contractor for the mitigation project as long as such contractor meets all qualification, certification, or licensing requirements in general law. A mitigation project must be performed by a properly licensed contractor who has secured all required local permits necessary for the project. The department must electronically verify that the contractor's state license number is accurate and up to date before approving a grant application.

(c) An association awarded a grant must complete the entire mitigation project in order to receive the final grant award and must agree to make the property available for a final inspection once the mitigation project is finished to ensure the mitigation improvements are completed in a matter consistent with the intent of the pilot program and meet or exceed the applicable Florida Building Code requirements. Construction must be completed and the association must submit a request to the department for a final inspection, or request an extension of time, within 1 year after receiving grant approval. If the association fails to comply with this paragraph, the application is deemed abandoned and the grant money reverts back to the department.

(d) All grants must be matched on the basis of $1 provided by the association for $2 provided by the state up to a maximum contribution as provided in the General Appropriations Act.

(e) When recommended by a hurricane mitigation inspection report, grants for eligible associations may be used for the following improvements:

1. Opening protection.

2. Exterior doors, including garage doors.

3. Reinforcing roof-to-wall connections.

4. Improving the strength of roof-deck attachments.

5. Secondary water barrier for roof.

(f) Grants may be used for a previously inspected existing structure on the property or for a rebuild.

(g)1. If improvements to protect the property which complied with the current applicable building code at the time have been previously installed, the association must use a

mitigation grant to install improvements that do both of the following:

a. Comply with or exceed the applicable building code in effect at the time the association applied for the grant.

b. Provide more hurricane protection than the improvements that the association previously installed.

2. The association may not use a mitigation grant to:

a. Install the same type of improvements that were previously installed; or

b. Pay a deductible for a pending insurance claim for damage that is part of the property for which grant funds are being received.

(h) The department shall develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility.

(6) CONTRACT MANAGEMENT.—

(a) The department may contract with third parties for grant management, inspection services, contractor services, information technology, educational outreach, and auditing services. Such contracts are considered direct costs of the pilot program and are not subject to administrative cost limits. The department shall contract with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and shall ensure the highest accountability for use of state funds, consistent with this section.

(b) The department shall implement a quality assurance and reinspection program that determines whether initial inspections and mitigation improvements are completed in a manner consistent with the intent of the pilot program. The department may use a valid random sampling in order to perform the quality assurance portion of the pilot program.

(7) REPORTS.—By February 1 of each year, the department shall submit a report to the President of the Senate and the Speaker of the House of Representatives on the activities of the pilot program and the use of state funds. The report must include all of the following information:

(a) The number of inspections requested.

(b) The number of inspections performed.

(c) The number of grant applications received.

(d) The number of grants approved and the monetary value of each grant.

(e) The estimated average annual amount of insurance premium discounts each association received and the total estimated annual amount of insurance premium discounts received by all associations participating in the pilot program.

(f) The estimated average annual amount of insurance premium discounts each unit owner received as a result of the improvements to the building or structure.

Section 2. This act shall take effect July 1, 2024.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1366
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/06/2024 adopted 1 DiCeglie					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
VA		Torres						
X		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
11	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1640
INTRODUCER:	Senator Collins
SUBJECT:	Payments for Health Care Services
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			FP	

I. Summary:

SB 1640 creates several consumer protections relating to the collection of medical debt and creates price transparency requirements for hospitals, ambulatory surgical centers (ASC) and insurers relating to nonemergency services. In regards to the collection of hospital and ASC medical debt, the bill:

- Prohibits a hospital or ASC from engaging in extraordinary collections actions, such as certain legal or judicial processes including commencing a civil action, garnishing wages or placing a lien on property.
- Establishes a three-year statute of limitations for actions to collect medical debt, which runs from the later of the date on which the facility completes written notification of the medical debt or the date on which the facility refers the medical debt to a third-party for collection. Currently, medical debt is subject to a five-year statute of limitation.
- Exempts from attachment, garnishment or other legal process in an action on hospital medical debt:
  - A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle. Currently, the exempt interest is $1,000.
  - A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption. Currently, the exempt interest is $1,000.

SB 1640 also includes the following price transparency requirements:

- A hospital or ASC must post standard charges for specified services on its website and establish a process for reviewing and responding to grievances from patients.
- Hospitals and ASCs must provide estimates of anticipated charges for nonemergency services and provide such estimates to the patient's health insurer.
- A health insurer, in turn, must prepare an "advanced explanation of benefits" for the patient, within a specified time frame prior to the service being provided, based on the facility's estimate.

The bill also revises the current voluntary shared savings incentive program for insurers participating in the individual market to make the program mandatory for such insurers.

The bill expands the health care providers that may participate in a direct health care agreement that is exempt from the insurance code to include a health care provider licensed under ch. 490 (practice of psychology) or ch. 491, F.S. (clinical, counseling, and psychotherapy services).

The fiscal impact of the bill, relating to the enforcement of the federal transparency requirements for hospitals and ASCs by the Agency for Health Care Administration is indeterminate. The Office of Insurance Regulation estimates that changing the shared savings program from a voluntary to mandatory program for insurers and HMOs will require an additional $193,000 salaries and benefits and $150,000 in rate to upgrade, recruit, and fill specific positions to accommodate the additional workload.

II. Present Situation:

Office of Insurance Regulation

In Florida, the Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities. To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR and comply with the requirements of the Florida Insurance Code. The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency. As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care. Rates and forms for health insurers and HMOs are subject to prior approval by the OIR.[1] Such rates may not be excessive, inadequate, or unfairly discriminatory.[2]

The federal Patient Protection and Affordable Care Act (PPACA)[3] requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the medical loss ratio (MLR).[4] It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. The PPACA requires insurers that provide coverage to small businesses and individuals to spend at least 80 percent of their premium income on health care claims and quality improvement, leaving the remaining 20 percent for administration, marketing, and profit.[5] Large group plans must spend at least 85 percent of premium dollars on medical care.[6] If an insurer fails to meet the applicable MLR standard in any given year, the issuer is required to provide a rebate to its customers.

[1] Part I, ch. 627, F.S.
[2] *Id*.
[3] Pub. L. 111-148, Mar. 23, 2010.
[4] Medical Loss Ratio | CMS (last visited Jan. 30, 2024)
[5] Medical Loss Ratio: Getting Your Money's Worth on Health Insurance | CMS (last visited Jan. 30, 2024).
[6] *Id*.

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program must be counted as medical expenditures.[7] Thus, a health insurer or HMO providing shared savings to insureds or subscribers will receive an equivalent credit towards meeting the MLR standards established by PPACA.

Florida Shared Savings Programs[8]

In 2019, the Legislature created a voluntary shared savings program for the commercial insurance market, which allows health insurers and health maintenance organizations (HMOs) to provide financial incentives to insureds with individual policies or contracts when they obtain health care services offered by their health insurer or HMO through their shared savings list. Participation is voluntary and optional for insureds and subscribers. The shoppable health care services are lower-cost, non-emergency services for which a shared savings incentive is available for insureds under the program. An established program may offer a shared savings incentive payment to an insured who receives treatment from a comprehensive list of more than 25 individual entities or groups that provide a health care service; this includes hospitals, physicians, nursing homes, pharmacies, and others.[9] Health insurers offering a shared savings incentive program must submit an annual report to the Office of Insurance Regulation (OIR) regarding the performance of the program. Currently, one insurer is participating in the voluntary program.

On January 1, 2019, the Division of State Group Insurance of the Department of Management Services instituted a voluntary shared savings program to reward insureds, subscribers, or their dependents for making informed and cost-effective decisions about health care spending.[10] The program allows participants to earn rewards by receiving rewardable healthcare services through two state vendors. Rewards are credited to a select pretax savings or spending account of the participant, and funds can be used to pay for eligible medical, dental, and vision expenses. Rewards are earned after the participant shops for a rewardable healthcare service on the website, receives the service, and the claim has been paid.[11] For fiscal year 2022-2023, total expenses for the program was $18.6 million. The program spent $9.6 million on claims, $6.3 million on administrative fees, and paid out $2.0 million in shared savings to employees.[12]

U.S. Health Care Spending

Major Payers of Health Care Spending

Highlights of the 2022 national health expenditures data[13] include:

[7] 45 CFR Part 158.
[8] Section 627.6387, 627.6648, and 641.31076, F.S.
[9] Ss. 627.6387, 627.6648, and 641.31076, F.S. The State Employee Group Program, which provides health care benefits to state employees, also offers a shared savings program, described in s. 110.12303, F.S.
[10] Ch. 2017-70, L.O.F.
[11] MyBenefits, Shared Savings Program, available at https://www.mybenefits.myflorida.com/health/shared_savings_program (last viewed Jan. 30, 2024).
[12] State Employees Group Health Self-Insurance Trust Fund, Exhibit II, Financial Outlook by Fiscal Year (Jan. 10, 2024) HealthInsuranceOutlook.pdf (state.fl.us) (last visited Jan. 20, 2024).
[13] Centers for Medicare and Medicaid, National Health Expenditure Data https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data (last visited Jan. 31, 2024).

- Private health insurance spending grew 5.9% to $1,289.8 billion in 2022, or 29 percent of total NHE.
- Out of pocket spending grew 6.6% to $471.4 billion in 2022, or 11 percent of total NHE.
- Hospital expenditures grew 2.2% to $1,355.0 billion in 2022, slower than the 4.5% growth in 2021.
- Physician and clinical services expenditures grew 2.7% to $884.9 billion in 2022, slower growth than the 5.3% in 2021.
- Prescription drug spending increased 8.4% to $405.9 billion in 2022, faster than the 6.8% growth in 2021.
- The largest shares of total health spending were sponsored by the federal government (33 percent) and the households (28 percent). The private business share of health spending accounted for 18 percent of total health care spending, state and local governments accounted for 15 percent, and other private revenues accounted for 7 percent.

In 2020, California's personal health care spending was highest in the nation ($410.9 billion), representing 12.2 percent of total U.S. personal health care spending. Comparing historical state rankings through 2020, California consistently had the highest level of total personal health care spending, together with the highest total population in the nation. Other large states, New York, Texas, Florida, and Pennsylvania, also were among the states with the highest total personal health care spending. [14] In 2020, the average per enrollee cost of private health insurance in Florida was $5.057. In comparison, the per capita personal health care spending ranged from $7,522 in Utah to $14,007 in New York.[15] The national average for per capita spending was $10,191.[16]

U.S. Health Outcomes

Although the United States spends more of its gross domestic product on health care than any other country, the U.S. has the highest rate of infant deaths as well as the highest rate of preventable deaths.[17] Many experts suggest that these longstanding, widespread problems stem in part from the misaligned incentives built into the traditional, fee-for-service payment model.[18] Under fee-for-service, health care providers, such as physicians and hospitals, are paid for each service they provide, resulting rewards for greater utilization or volume, they are paid more if they deliver more services, even if they don't achieve desired results.

Value-Based Payment Models

In response to concerns about rising medical costs, greater utilization of services, and quality of outcomes, many insurers and HMOs have implemented value-based health care payment models (e.g., bundled payments) with providers, which aim to change that dynamic, so physicians earn more for delivering health care that helps patients have better outcomes, while also keeping costs down, thereby reducing costs and inefficiencies in the health care system.

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[14] National Health Expenditures Fact Sheet, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last visited Jan. 20, 2024).
[15] State Health Expenditure Accounts by State of Residence Highlights https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/res-highlights.pdf (last visited Jan. 20, 2024).
[16] *Id.*
[17] Value-Based Care: What It Is, and Why It's Needed | Commonwealth Fund (Feb. 7, 2023).
[18] *Id.*

Medical Debt

Medical debt, or personal debt incurred from unpaid medical bills, is a leading cause of bankruptcy in the United States. Two-thirds of medical debts are the result of a one-time or short-term medical expense arising from an acute medical need.[19] Many medical collections on consumer credit reports are low-dollar accounts. Data from the CFPB's Consumer Credit Panel show that in 2020, the median medical collection was $310, the mean medical collection was $773, and 62 percent of medical collections were under $490.[20] In Florida, approximately 14.3 percent of the population has medical debt in collection.[21] The median amount of medical debt in collections is $915.[22] The percentage of persons without health insurance coverage is 12.1 percent.[23] Medical debt is the most common collection information reported on consumer credit records.[24]

The Urban Institute analysis found that, as of December 2020, among people who had at least one medical collection on their credit record, the median person owed a total of $797 in medical debt.[25] Additionally, some medical debts are not included on credit records but may be captured in surveys.

Medical Debt Collection Process in Florida

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[26] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[27]

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[19] Hamel, Liz et al. "The Burden of Medical Debt: January 2016 Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." Kaiser Family Foundation. January 2016. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (kff.org) (last visited Jan. 20, 2024).
[20] Medical Debt Burden in the United States (consumerfinance.gov). (last visited Jan. 28, 2024).
[21] Debt in America: State-Level Medical Debt | Urban Data Catalog (Sep. 14, 2023) and Debt in America: An Interactive Map; Technical Appendix (urban-data-catalog.s3.amazonaws.com) (last visited Jan. 28, 2024).
[22] *Id.*
[23] *Id.*
[24] Furey, Michael and Ryan Kelly. "Market Snapshot: Third-Party Debt Collections Tradeline Reporting." Consumer Financial Protection Bureau. July 18, 2019. https://files.consumerfinance.gov/f/documents/201907_cfpb_thirdparty-debt-collections_report.pdf. (last visited Jan. 25, 2024).
[25] Debt in America: An Interactive Map (urban.org) (last visited Jan. 24, 2024).
[26] Art. X, s. 4(a), Fla. Const.
[27] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[28] proceeds from life insurance policies;[29] wages or unemployment compensation payments due certain deceased employees;[30] disability income benefits;[31] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[32] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[33]

Bankruptcy is a means by which a person's assets are liquidated in order to pay that person's debts under court supervision. The U.S. Constitution gives Congress the right to uniformly govern bankruptcy law.[34] Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code provides for exempt property in a bankruptcy case.[35] In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[36] Florida, like most states, has made the opt-out election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[37]

Federal and Other State Laws Governing Medical Debt Collections

The Consumer Financial Protection Bureau's (CFPB) debt collection final rule, which revised Regulation F, the rule implementing the Fair Debt Collection Practices Act (FDCPA), took effect November 30, 2021. The FDCPA and Regulation F, apply to "debt collectors,"[38] as that term is defined in the statute, including, in general, debt collectors collecting medical debts. Generally the FDCPA and Regulation F do not apply to medical service providers or their employees who attempt to collect debts owed to the provider. The FDCPA and Regulation F prohibit, among other things, using "unfair or unconscionable means to collect or attempt to collect any debt."

Among other changes, the final rule prohibits "debt parking," also known as passive or delayed collections. This is the practice of furnishing collection information about a debt to a consumer

[28] Section 222.11, F.S.
[29] Section 222.13, F.S.
[30] Section 222.15, F.S.
[31] Section 222.18, F.S.
[32] Section 222.22, F.S.
[33] Section 222.25, F.S.
[34] Art. 1, s. 8, cl. 4, U.S. Const.
[35] 11 U.S.C. s. 522.
[36] 11 U.S.C. s. 522(b).
[37] Section 222.20, F.S.
[38] Under the FDCPA, a debt collector is "any person who uses any instrumentality of interstate commerce or the mails in any business the principal purpose of which is the collection of any debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due another." The FDCPA additionally provides certain exemptions from this definition.

reporting company before communicating with the consumer about the debt.[39]210 This practice was previously employed by some medical debt collectors, who would report a debt to a consumer reporting company, then wait for the debtor to notice the reported debt when, for example, applying for credit. Regulation F addresses the practice of "debt parking" by requiring a debt collector to take certain actions intended to convey information about the debt to the debtor before furnishing information about that debt to a consumer reporting company.

The FDCPA and Regulation F also require debt collectors, including medical debt collectors, to provide certain information about the debt to consumers at or near the outset of collections. Regulation F requires debt collectors to include, as part of this information, an itemization of the current amount of the debt. This itemization may help individuals recognize and understand medical debts in collection.

State Laws Relating to Financial Assistance for Patients with Medical Bills

Some hospitals and managed care organizations have financial assistance programs that aim to reduce financial burdens for low-income patients. Under the federal Affordable Care Act (ACA), nonprofit hospitals are required to offer financial assistance to patients.[40] Certain states also require hospitals to offer programs to help patients with medical bills. Eligibility for these programs varies. Several states—including California, Connecticut, Illinois, Maine, Maryland, Nevada, New Jersey, New York, Rhode Island, and Washington—require discounted or free care for people with low incomes.[41] Certain states extend these protections to those with moderate incomes, as well. In most states, the mandates apply to all hospitals, but in some states, mandates cover only nonprofit, publicly funded, rural, or critical-access hospitals.

State Laws and Consumer Protection Related to Medical Debt Collection

Further, states such as Maryland, Nevada, New Mexico,[42] California, and Washington have enacted legislation providing expanded protections relating to disclosures, delayed credit reporting, and debt collection, as described below:

- Washington (law effective July 28, 2019). Prohibits health care providers and facilities from selling or assigning medical debt until at least 120 days after the initial billing statement. Prohibits certain practices with respect to medical debt, including the reporting of adverse information to consumer credit reporting agencies or credit bureaus until at least 180 days after the original obligation was received by the licensee for collection or by assignment; and, if the claim involves hospital debt, failure to include certain information regarding charity care or collection during the pendency of an application for charity care about which the licensee has received notice.[43]

[39] FTC Stops Debt Collector's Alleged "Debt Parking" Scheme, Requires it to Delete Debts it Placed on Consumers' Credit Reports (Nov. 30, 2020). https://www.ftc.gov/news-events/news/press-releases/2020/11/ftc-stops-debt-collectors-alleged-debt-parking-scheme-requires-it-delete-debts-it-placed-consumers (last visited Jan. 29, 2024).
[40] 26 U.S.C. s. 501(r).
[41] Medical Debt Burden in the United States (consumerfinance.gov) (last visited Jan. 29, 2024).
[42] SB0071JUS2 (nmlegis.gov) New Mexico Legislature. (last visited Jan. 29, 2024).
[43] 1531-S HBR FBR 19.pdf (wa.gov) Washington House. (last visited Jan. 28, 2024).

- Maryland (law effective January 1, 2021). Specifies the method for calculating family income to be used to consider free or reduced-cost medic\al care under a certain hospital financial assistance policy; and prohibits a hospital from charging interest or fees on certain debts incurred by certain patients.[44]
- California (law effective January 1, 2022). Prohibits a hospital from selling patient debt to a debt buyer, unless specified conditions are met, including that the hospital has found the patient ineligible for financial assistance or the patient has not responded to attempts to bill or offer financial assistance for 180 days. Requires that uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level be eligible for charity care or discount payments from a hospital, and authorizes a hospital to grant eligibility for charity care or discount payments to patients with incomes over 400 percent of the federal poverty level. Prohibits debt collection before 180 days after the initial billing.[45]
- Nevada (law effective July 1, 2021). Requires a collection agency to notify a debtor 60 days before taking any action to collect a medical debt; providing certain protections to a medical debtor who initiates contact with or makes a voluntary payment to a collection agency; prohibiting certain practices relating to the collection of medical debt; prohibiting the waiver of certain protections provided to medical debtors.[46]

Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[47] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[48] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[49] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[50] Estimates must be written in language "comprehensible to an ordinary layperson."[51] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition

[44] Legislation - SB0514 (maryland.gov) Maryland General Assembly. (last visited Jan. 22, 2024).
[45] Bill Text - AB-1020 Health care debt and fair billing. California Legislative Information. (last visited Jan. 22, 2024).
[46] SB248 Text (state.nv.us) Nevada Legislature. (last visited Jan. 28, 2024)
[47] Section 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[48] Section 381.026(3), F.S.
[49] Section 381.026(4)(c), F.S.
[50] Section 381.026(4)(c)3., F.S.
[51] *Id.*

warrant.[52] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[53]

Currently, under the financial information and disclosure provisions in the Patient's Bill of Rights:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or the AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[54]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[55] to publish a schedule of charges for the medical services offered to patients.[56] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[57] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[58] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single two-year period.[59]

[52] *Id.*
[53] Section 381.026(4)(c)5., F.S.
[54] Section 381.0261, F.S.
[55] Section 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[56] Section 381.026(4)(c)3., F.S.
[57] *Id.*
[58] *Id.*
[59] Section 381.026(4)(c)4., F.S.

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[60] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures, and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[61] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day, until the schedule is published and posted.[62]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[63] must provide, within seven days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[64] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also, pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[65] Under s. 408.05, F.S., the AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[66]

[60] Section 395.107(1), F.S.
[61] Section 395.107(2), F.S.
[62] Section 395.107(6), F.S.
[63] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[64] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity.
[65] Section 395.301, F.S.
[66] Section 408.05(3)(c), F.S.

Hospitals and other facilities post a link to this site – known as Florida Health Finder – to comply with the price transparency requirements. The cost information is searchable, based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[67]

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[68]

Federal Transparency Requirements - Hospitals

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[69] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, the federal CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges and a consumer-friendly presentation of prices for at least 300 "shoppable" health care services. The regulations became effective on January 1, 2021.[70]

The regulations define a "shoppable" service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[71]

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[67] *Id.*
[68] Section 456.0575(2), F.S.
[69] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019) (codified at 45 CFR Part 180).
[70] *Id.*
[71] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019) (codified at 45 CFR Part 180).

Federal Oversight and Enforcement Relating to Price Transparency Requirements for Hospitals

The federal hospital transparency requirements were effective January 1, 2021. To be fully compliant, a hospital must have a complete machine-readable standard charge file; and either a consumer friendly 300 shoppable services list; or an online price estimator tool. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[72] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[73] Another review of more than 6,400 hospitals in 2022 indicated widespread non-compliance with the federal transparency rule in that more than 63 percent of hospitals were estimated to be non-compliant.[74] According to that review, only 38 percent of Florida hospitals were in compliance.[75]

In response to compliance concerns, the Centers for Medicare and Medicaid Services (CMS) has increased the number of comprehensive reviews conducted from 30-40 per month to over 200 comprehensive reviews per month.[76] As of April 2023, CMS has issued more than 730 warning notices and 269 requests for corrective action plans (CAPs). The CMS has imposed CMPs on six hospitals for noncompliance and the CMPS on an additional eight hospitals, including a Florida hospital, are under review or appeal, which are posted and made publicly available on the CMS website. As part of the monitoring and enforcement efforts, CMS[77] is updating the enforcement process, with respect to areas that do not require rulemaking, with the following changes:

- **Requiring CAP completion deadline.** CMS will continue to require hospitals that are out of compliance with the hospital price transparency regulation to submit a CAP within 45 days from when CMS issues the CAP request. CMS will also now require hospitals to be in full compliance with the hospital price transparency regulation within 90 days from when CMS issues the CAP request, rather than allowing hospitals to propose a completion date for CMS approval which can vary. This change will standardize and streamline the timeframe and promote compliance at earlier dates.
- **Imposing CMPs earlier and automatically**. Currently, CMS does not impose automatic CMPs for failure to submit a requested CAP or failure to come into compliance within 90 days from when a CAP request is issued. CMS will now automatically impose a CMP on hospitals that fail to submit a CAP at the end of the 45-day CAP submission deadline. Before imposing the CMP, CMS will re-review the hospital's files to determine whether any of the violations cited in the CAP request continue to exist and, if violations are found, impose a CMP. For hospitals that submit a CAP by the 45-day CAP submission deadline but fail to comply with the terms of that CAP by the end of the 90-day deadline, CMS will re-review

[72] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last visited Jan. 31, 2024).
[73] *Id.*
[74] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last visited Jan. 31, 2024).
[75] *Id., p.* 4.
[76] Hospital Price Transparency Enforcement Updates | CMS (Apr. 26, 2023) (last visited Jan. 17, 2024).
[77] *Hospital Price Transparency Enforcement Updates | CMS* (last visited Jan. 17, 2024).

the hospital's files to determine whether any of the violations cited in the CAP request continue to exist and, if so, impose an automatic CMP.

- **Streamlining the compliance process.** For hospitals that have not made any attempt to satisfy the requirements (i.e., those that have not posted any machine-readable file or shoppable services list/price estimator tool), CMS will no longer issue a warning notice to the hospital and will instead immediately request that the hospital submit a CAP. Currently, CMS does not issue CAP requests without first issuing a warning notice.

The CMS notes that these enforcement updates will shorten the average time by which hospitals must come into compliance with the hospital price transparency requirements after a deficiency is identified to no more than 180 days, or 90 days for cases with no warning notice, and will complement future efforts.[78]

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services, Labor, and Treasury finalized Transparency in Coverage regulations[79] imposing new transparency requirements on issuers of individual and group health insurance plans.

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.[80]

Federal Oversight and Enforcement of Transparency in Coverage Requirements

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an internet-based self-service tool and in paper form, upon request.[81] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments[82] in Table 1 of the preamble

[78] *Id.*

[79] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).

[80] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers, November 1, 2020, available at* https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited Jan. 23, 2024).

[81] 26 CFR 54.9815-2715A2(b); 29 CFR 2590.715-2715A2(b); and 45 CFR 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. See also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf, and FAQs about Affordable Care Act Implementation Part 61 (cms.gov) (Sep 27, 2024) (last visited Jan.19, 2024).

[82] Department of Treasury, Department of Labor, and Department of Health and Human Services.

to the TiC Rules,[83] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[84]

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the insured's or subscriber's request.[85] Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.[86]

For plans and issuers that are subject to CMS's enforcement authority and do not comply, CMS may take several enforcement actions, including: requiring corrective actions or imposing a civil money penalty up to $100 per day, adjusted annually under 45 CFR part 102, for each violation and for each individual affected by the violation.[87]

The Federal "No Surprises" Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[88] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act go into effect on January 1, 2022, and the federal departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[89]

Federal No Surprises Act Requirements Relating to Estimates – Facilities

The No Surprises Act requires a health insurer or health maintenance organization (HMO) to generate an "advanced explanation of benefits" (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).[90]

Federal No Surprises Act Requirements of Health Insurers and HMOs

[83] 85 FR 72158, 72182-90 (Nov. 12, 2020).
[84] 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1).
[85] In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 CFR 54.9815-2715A2(b)(2)(ii); 29 CFR 2590.715-2715A2(b)(2)(ii); and 45 CFR 147.211(b)(2)(ii).
[86] 26 CFR 54.9815-2715A2(b)(1); 29 CFR 2590.715-2715A2(b)(1); and 45 CFR 147.211(b)(1).
[87] 45 CFR part 150, subpart B and C.
[88] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[89] *Id.*
[90] Public Law 116-260, Division BB, Section 112.

Under the No Surprises Act, once the "good faith estimate" has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's insurer's or HMO's network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health insurer or HMO;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's policy or contract;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[91]

Deferral of Federal Enforcement Related to the Good Faith Estimates and the AEOBs for Insured Individuals[92]

The Department of Health and Human Services issued regulations implementing Public Health Services Act (PHS Act) s. 2799B-6 related to good faith estimates for uninsured or self-pay individuals in interim final rulemaking that was published in the Federal Register on October 7, 2021, but deferred enforcement of the portion of PHS Act s. 2799B-6 related to good faith estimates for insured individuals who are seeking to have a claim submitted to insurer or HMO for scheduled items or services.[93] In the preamble to that rule (and as stated in guidance issued by the Departments), the Departments also deferred enforcement of Code section 9816(f), ERISA section 716(f), and PHS Act section 2799A–1(f) related to the requirement that plans and issuers provide an AEOB.[94]

The decision to defer enforcement in October 2021 was made in response to stakeholder requests that the Departments first establish standards for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers. The Departments agreed that compliance with

[91] Public Law 116-260, Division BB, Section 111.
[92] 87 FR 56905.
[93] Requirements Related to Surprise Billing; Part II, 86 FR 55980, 55983 (October 7, 2021), available at *https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii*. (last visited Jan. 24, 2024).
[94] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (August 20, 2021), Q6, available at *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf*. (last visited Jan. 29, 2024).

these sections was likely not possible by January 1, 2022, and indicated an intent to undertake notice and comment rulemaking in the future to implement these provisions, including establishing appropriate data transfer standards. In September 2022, issued a Request for Information relating to the AEOB and the GFE for covered individuals. In the September 2022 Request for Information, noticed in the Federal Register, it was stated that HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, and the Departments are deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB until the notice and comment rulemaking, including the establishment of appropriate data transfer standards is accomplished.

III. Effect of Proposed Changes:

Medical Debt Protections for Consumers

SB 1640 amends and creates several sections of law in order to establish new protections for consumers who owe medical debt to a hospital or ambulatory surgical center (ASC).

Section 1 amends s. 95.11, F.S., to establish that the statute of limitations for an action to collect medical debt for services rendered by a hospital or ASC licensed under ch. 395, F.S., is three years, running from the date on which the facility completes written notification of the medical debt or the date on which the facility refers the medical debt to a third-party for collection, whichever is later. Medical debt is currently subject to a five-year statute of limitations under s. 95.11(2)(b), F.S.

Section 2 creates s. 222.26, F.S., to exempt from attachment, garnishment or other legal process in an action on hospital medical debt:

- A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle. Currently, the exempt interest is $1,000.
- A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption. Currently, the exempt interest is $1,000.

Section 4 creates s. 395.3011, F.S., to prohibit a hospital or ASC from engaging in certain billing and collection activities relating to medical debt. The bill defines "extraordinary collection actions" to mean any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

- Selling the individual's debt to another party.
- Reporting adverse information about the individual to consumer credit reporting agencies.
- Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.
- Actions that require a legal or judicial process, including, but not limited to:
  - Placing a lien on the individual's property;
  - Foreclosing on the individual's real property;

- Attaching or seizing the individual's bank account or any other personal property;
- Commencing a civil action against the individual;
- Causing the individual's arrest; or
- Garnishing the individual's wages.

The bill prohibits a hospital or ASC from engaging in an extraordinary collection action to obtain payment for services in the following circumstances:

- Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance;
- Before the facility has provided the individual with an itemized statement or bill;
- During an ongoing grievance process as described in s. 395.301(6), F.S., or an ongoing appeal of a claim adjudication;
- Before billing any applicable insurer or HMO and allowing the insurer or HMO to adjudicate a claim;
- For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient; or
- While the individual:
  - Negotiates in good faith the final amount of a bill for services rendered; or
  - Complies with all terms of a payment plan with the facility.

Section 3 amends s. 395.301, F.S., to require each hospital and ASC to establish an internal process for reviewing and responding to grievances from patients. The process must allow a patient to dispute charges that appear on the patient's itemized statement or bill and the facility must prominently post on its website and print on each itemized statement or bill, in bold print, the instructions for initiating, and the direct contact information required to initiate, a grievance. The facility must respond to a patient's grievance within seven business days after the patient formally files the grievance.

Price Transparency Provisions Relating to Hospitals and ASCs

Section 3 amends s. 395.301, F.S., to require a hospital or an ASC to post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If the facility posts less than 300 services, it must include each service it provides. The bill defines:

- "Shoppable health care service" to mean a service that can be scheduled by a health care consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e), F.S.,[95] and any services defined in regulations or guidance issued by the U.S. Department of Health and Human Services.

[95] These services include clinical laboratory services, infusion therapy, inpatient and outpatient surgical procedures, obstetrical and gynecological services, inpatient and outpatient nonsurgical diagnostic tests and procedures, physical and occupational therapy services, radiology and imaging services, prescription drugs, services provided through telehealth, and any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(m).

- "Standard charge" to mean the same as that term is defined in regulations or guidance issued by the U.S. Department of Health and Human Services for purposes of hospital price transparency.

The bill also amends provisions requiring a hospital or ASC to provide a good faith estimate for nonemergency medical services to a patient. The bill requires this estimate to be provided to the patient or prospective patient upon scheduling the medical service, rather than within seven days of receiving the request for the service as under current law, and also requires the facility to provide the estimate to the patient's health insurer[96] and to the patient at least three business days before the service but no more than one business day after the service is scheduled, or three business days after the service is scheduled if the service is scheduled at least ten days in advance.

The bill removes current-law provisions that require the facility to take action to educate the public that such estimates are available upon request and that specify that the estimate does not preclude the actual charges from exceeding the estimate.

Advanced Explanation of Benefits Required of Insurers and HMOs

Section 6 creates s. 627.445, F.S., to require a health insurer to prepare an "advanced explanation of benefits" (AEOB) after receiving an estimate from a hospital or ASC. The bill defines "health insurer" as a health insurer issuing individual or group coverage or a HMO issuing coverage through an individual or a group contract. The AEOB must be provided to the patient no later than one business day after the insurer receives the estimate or no later than three business days for services scheduled at least ten business days in advance. At a minimum, the AEOB must include detailed coverage and cost-sharing information pursuant to the federal No Surprises Act.

Disclosure of Discounted Cash Prices

Section 7 creates s. 627.447, F.S., to provide that an insurer may not prohibit a provider from disclosing to an insured the option to pay the provider's discounted cash price for services. The term, "discounted cash price," means:

- With respect to a hospital facility, the term has the same meaning as provided in 45 C.F.R. s. 180.20. The term does not include the amount charged to an individual pursuant to a facility's financial assistance policy.
- With respect to a provider that is not a hospital, the term means the charge that is applied to an individual who paid for a health care service without filing an insurance claim.

Shared Savings Incentive Program (Sections 8-10)

[96] As defined in s. 627.445(1), F.S.

These sections amend ss. 627.6387, 627.6648, and 641.31076, F.S. to specify that a health insurer or health maintenance organization must count a shared saving incentive program as a medical expense for rate development and rate filing purposes.[97]

The program is revised to provide that it is mandatory for an insurer writing individual policies.

The program remains voluntary and optional for insureds.

Direct Health Care Agreements

Section 5 amends s. 624.27, F.S., to expand the definition of health care provider that may participate in a direct health care agreement that is exempt from the insurance code to include a health care provider licensed under ch. 490 (practice of psychology) or ch. 491, F.S. (clinical, counseling, and psychotherapy services). Currently, physicians licensed under chapter 458, osteopaths licensed under chapter 459, chiropractors licensed under chapter 460, podiatric physicians licensed under chapter 461, nurses and certified nursing assistants licensed under chapter 464, or dentists licensed under chapter 466, or a health care group practice, who provides health care services to patients are authorized to participate in direct health care agreements. Direct health care agreements are contracts between providers and a patient that are exempt from the insurance code if the agreement is in writing, discloses the scope of the services, duration of the agreement, monthly fees, and any fees for health care services not covered by the monthly fee. Further, the agreement must offer a refund to the patient of monthly fees paid in advance if the provider ceases to offer the services for any reason.

Conforming Changes (Sections 11-15)

The bill amends ss. 475.01, 475.611, 768.28, and 787.061, F.S., to make conforming cross-reference changes.

Effective Date (Section 16)

The bill provides an effective date of October 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[97] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019) (codified at 45 CFR Part 180).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Article II, Section 3, of the Florida Constitution has been interpreted by Florida courts to prohibit the Legislature from delegating its legislative power to others. Under this non-delegation principle, Florida courts have held that the Legislature may enact laws that adopt federal statutes or other federal regulations in existence and in effect at the time the Legislature acts; however, if the Legislature incorporates into a Florida statute a future federal act or regulation, courts have held that such incorporation constitutes an unconstitutional delegation of legislative power.

However, when a statute incorporates a federal law or regulation by reference, in order to avoid holding the subject statute unconstitutional, Florida courts generally interpret the statute as incorporating only the federal law or regulation in effect on the date of the Legislature's action to enact the Florida law, reasoning that the Legislature is presumed to have intended to enact a valid and constitutional law.

Lines 166-171 of the bill define the terms "shoppable health care service" and "standard charge" with reference to how those terms are defined in "regulations or guidance issued by the United States Department of Health and Human Services." Considering that the bill does not specify that it is referring to such definitions as they exist at a specific date prior to the enactment of the bill, these references may be considered an unauthorized delegation of legislative powers if interpreted to make reference to future revisions of those definitions in federal law and may be interpreted to maintain the meaning of how those federal definitions stand on the date the bill becomes effective instead of incorporating such future revisions.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1640 may have an indeterminate positive fiscal impact on consumers of health care services at hospitals and ASCs by providing additional price information prior to the consumer obtaining a health care service and through protecting the consumer against certain debt collection practices for medical debt.

The bill may have an indeterminate negative fiscal impact on hospitals, ASCs, health insurers, and HMOs related to complying with the new state requirements in the bill and on hospitals and ASCs that may not be able to collect on medical debt that they may have collected prior to the passage of the bill.

C. Government Sector Impact:

The Office of the State Courts Administrator

The Office of the State Courts Administrator reports that the State Courts System receives $195 in filing fees for each civil proceeding, and those funds are deposited into the State Courts Revenue Trust Fund (SCRTF). To the extent that the number of such proceedings will be reduced by the bill's prohibition against hospitals and ASCs pursuing "extraordinary collection activities," combined with the bill's other limitations related to the collection of medical debt, the bill will negatively impact deposits into the SCRTF. The extent of this impact is indeterminate.[98]

Agency for Health Care Administration (Agency)

The fiscal impact on Agency is indeterminate at this time. The bill increases the regulation of hospitals and ASCs, both of which are currently licensed and regulated by the Agency.

Office of Insurance Regulation[99]

The OIR provides a fiscal impact related to implementing a mandatory shared savings program for insurers and HMOs to offer insureds and subscribers. Implementation of the bill would require all health insurers, and HMOs to file new forms and annually thereafter file forms with the office for review as part of the contract, and submit annual rate filings for review. Since only one insurer currently offers this type of program, this would require additional work and training for OIR staff. To ensure the products are thoroughly reviewed and readily available in the market, OIR would need $150,000 in rate and $193,000 in Salaries and Benefits to upgrade, recruit, and fill specific positions to accommodate the workload.

VI. Technical Deficiencies:

Lines 182-184 of the bill require a hospital or ambulatory surgical center (ASC) to provide the good faith estimate to a patient "upon scheduling a medical service." However, lines 191-192 require the facility to provide the estimate to the patient "no later than one business day after the service is scheduled" (or three business days in certain scenarios). As such, it is unclear when a facility is required to provide the estimate to the patient or whether the facility must provide the estimate to the patient twice.

[98] Office of the State Courts Administrator, *2024 Judicial Impact Statement: SB 1640* (Jan. 24, 2024) (on file with the Senate Committee on Banking and Insurance).
[99] Office of Insurance Regulation, 2024 SB 1640 Analysis. On file with Senate Banking and Insurance Committee.

VII. Related Issues:

Line 190 requires the good faith estimate to be provided by the hospital or ambulatory surgical center (ASC) to the health insurer and to the patient "at least 3 business days before a service is to be furnished." It may be impossible for a facility to meet this deadline if a service is to be furnished less than three days after it is scheduled and may preclude services from being furnished less than three days after they are scheduled.

The change to the statute of limitations to collect medical debt may result in fewer actions being barred by the statute of limitations as hospitals and ASCs could determine when the statute of limitations begins to run by delaying written notice of the debt or transfer medical debt to collection agencies.[100]

Many insurers and HMOs have implemented value-based value based purchasing or alternative payment methodologies that are tied to certain insurer-specific quality improvement or outcome strategies. Often such payment methodologies bundle services. It is unclear whether the information relating to the shared savings program includes outcome measures that a consumer may use to also evaluate the quality of care delivered by a provider.

VIII. Statutes Affected:

This bill amends sections 95.11, 395.301, 624.27, 627.447, 627.6387, 627.6648, 641.31076, 475.01, 475.611, 517.191, 768.28, and 787.061 of the Florida Statutes.
This bill creates sections 226.26, 395.3011, and 627.446, of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[100] Supra at 98.

By Senator Collins

14-01322B-24 20241640__

A bill to be entitled

An act relating to payments for health care services; amending s. 95.11, F.S.; establishing a 3-year statute of limitations for an action to collect medical debt for services rendered by certain health care facilities; creating s. 222.26, F.S.; providing additional personal property exemptions from legal process for medical debts resulting from services provided in certain licensed facilities; amending s. 395.301, F.S.; requiring certain licensed facilities to post on their respective websites a consumer-friendly list of standard charges for a minimum number of shoppable health care services; requiring the facilities to provide such information in an alternative format as requested by the patient; defining terms; requiring licensed facilities to provide a good faith estimate of reasonably anticipated charges to the patient's health insurer and the patient, prospective patient, or patient's legal guardian within specified timeframes; requiring such facilities to provide the estimate in the manner selected by the patient, prospective patient, or patient's legal guardian; revising notification requirements for such estimates to include notification of a patient's legal guardian, if any; deleting the requirement that licensed facilities educate the public on the availability of such estimates upon request; revising a penalty; deleting construction; requiring licensed facilities to

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establish an internal grievance process for patients to submit grievances, including to dispute charges; requiring licensed facilities to make available on their respective websites information necessary for initiating a grievance; requiring licensed facilities to respond to a patient grievance within a specified timeframe; requiring licensed facilities to disclose certain information to patients, prospective patients, and patients' legal guardians, as applicable; providing a civil penalty; creating s. 395.3011, F.S.; defining the term "extraordinary collection action"; prohibiting licensed facilities from engaging in extraordinary collection actions against individuals to obtain payment for services under specified circumstances; amending s. 624.27, F.S.; revising the definition of the term "health care provider" for purposes of direct health care agreements; creating s. 627.446, F.S.; defining the term "health insurer"; requiring health insurers to provide an insured with an advanced explanation of benefits after receiving a patient estimate from a facility for scheduled services; providing requirements for the advanced explanation of benefits; creating s. 627.447, F.S.; prohibiting health insurers from prohibiting providers from disclosing certain information to an insured; defining the term "discounted cash price"; amending s. 627.6387, F.S.; revising the definition of the terms "health insurer" and "shared savings incentive" to conform to changes made by the act; requiring, rather

than authorizing, health insurers to offer a shared savings incentive program under certain circumstances; requiring that a certain notification required of health insurers include specified information; providing that a shared savings incentive offered by a health insurer constitutes a medical expense for purposes of rate development and rate filing; amending ss. 627.6648 and 641.31076, F.S.; providing that a shared savings incentive offered by a health insurer or health maintenance organization, respectively, constitutes a medical expense for rate development and rate filing purposes; amending ss. 475.01, 475.611, 517.191, 768.28, and 787.061, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (4) through (12) of section 95.11, Florida Statutes, are redesignated as subsections (5) through (13), respectively, a new subsection (4) is added to that section, and paragraph (b) of subsection (2), paragraph (n) of subsection (3), paragraphs (f) and (g) of present subsection (5), and present subsection (10) of that section are amended, to read:

95.11 Limitations other than for the recovery of real property.—Actions other than for recovery of real property shall be commenced as follows:

(2) WITHIN FIVE YEARS.—

(b) A legal or equitable action on a contract, obligation,

or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (6)(e) ~~(5)(e)~~, s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (6)(h) ~~(5)(h)~~.

(3) WITHIN FOUR YEARS.—

(n) An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections ~~(4),~~ (5), (6), and (8) ~~(7)~~.

(4) WITHIN THREE YEARS.—An action to collect medical debt for services rendered by a facility licensed under chapter 395, provided that the period of limitations runs from the date on which the facility completes written notification of the medical debt, either through the mail or via electronic means with evidence of receipt, in the delivery manner selected by the affected patient or the patient's legal representative or the date on which the facility refers the medical debt to a third party for collection, whichever date is later.

(6) ~~(5)~~ WITHIN ONE YEAR.—

(f) Except for actions described in subsection (9) ~~(8)~~, a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.

(g) Except for actions described in subsection (9) ~~(8)~~, an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's confinement.

(11)~~(10)~~ FOR INTENTIONAL TORTS RESULTING IN DEATH FROM ACTS DESCRIBED IN S. 782.04 OR S. 782.07.—Notwithstanding paragraph (5)(e) ~~(4)(c)~~, an action for wrongful death seeking damages authorized under s. 768.21 brought against a natural person for an intentional tort resulting in death from acts described in s. 782.04 or s. 782.07 may be commenced at any time. This subsection shall not be construed to require an arrest, the filing of formal criminal charges, or a conviction for a violation of s. 782.04 or s. 782.07 as a condition for filing a civil action.

Section 2. Section 222.26, Florida Statutes, is created to read:

222.26 Additional exemptions from legal process concerning medical debt.—If a debt is owed for medical services provided by a facility licensed under chapter 395, the following property is exempt from attachment, garnishment, or other legal process in an action on such debt:

(1) A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle as defined in s. 320.01(1).

(2) A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption under s. 4, Art. X of the State Constitution.

Section 3. Present paragraphs (b), (c), and (d) of subsection (1) of section 395.301, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), respectively, present subsection (6) is redesignated as subsection (8), a new paragraph (b) is added to subsection (1), a new subsection (6) and subsection (7) are added to that section, and present

paragraph (b) of subsection (1) of that section is amended, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

(b) Each licensed facility shall post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If a facility provides fewer than 300 distinct shoppable health care services, it must make available on its website the standard charges for each service it provides. A facility shall provide the information in an alternative format as requested by the patient. As used in this paragraph, the term:

1. "Shoppable health care service" means a service that can be scheduled by a health care consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e) and any services defined in regulations or guidance issued by the United States Department of Health and Human Services.

2. "Standard charge" has the same meaning as the definition of that term in regulations or guidance issued by the United States Department of Health and Human Services for purposes of

hospital price transparency.

(c)1.~~(b)1.~~ ~~Upon request, and~~ Before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic means, in the manner requested by the patient, prospective patient, or patient's legal guardian, a good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition. Such estimate must be provided to the patient, prospective patient, or patient's legal guardian upon scheduling a medical service. The facility ~~must provide the estimate to the patient or prospective patient within 7 business days after the receipt of the request and~~ is not required to adjust the estimate for any potential insurance coverage. The facility shall provide the estimate to the patient's health insurer, as defined in s. 627.446(1), and the patient or the patient's legal guardian at least 3 business days before a service is to be furnished, but no later than 1 business day after the service is scheduled or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after the service is scheduled. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient, ~~or~~ prospective patient, or patient's legal guardian requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient, ~~or~~ prospective patient, or patient's legal guardian that he or she may contact the patient's ~~his or her~~ health insurer ~~or health maintenance organization~~ for additional information concerning

cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient, ~~or~~ prospective patient, or patient's legal guardian information delivered in the patient's preferred format on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient, ~~or~~ prospective patient, or patient's legal guardian that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. ~~Upon request,~~ The facility shall notify the patient, ~~or~~ prospective patient, or patient's legal guardian of any revision to the estimate.

5. In the estimate, the facility must notify the patient, ~~or~~ prospective patient, or patient's legal guardian that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

6. ~~The facility shall take action to educate the public that such estimates are available upon request.~~

~~7.~~ Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient, ~~or~~ prospective patient, or patient's legal guardian and the health insurer. The total fine per patient estimate may not exceed $10,000.

~~The provision of an estimate does not preclude the actual charges from exceeding the estimate.~~

(6) Each facility shall establish an internal process for reviewing and responding to grievances from patients. Such process must allow patients to dispute charges that appear on the patient's itemized statement or bill. The facility shall prominently post on its website and indicate in bold print on each itemized statement or bill the instructions for initiating a grievance and the direct contact information required to initiate the grievance process. The facility shall provide an initial response to a patient grievance within 7 business days after the patient formally files a grievance disputing all or a portion of an itemized statement or bill.

(7) Each licensed facility shall disclose to a patient, prospective patient, or a patient's legal guardian whether a cost-sharing obligation for a particular covered health care service or item exceeds the charge that applies to an individual who pays cash or the cash equivalent for the same health care service or item in the absence of health insurance coverage. The facility's failure to provide a disclosure compliant with this section may result in a fine not to exceed $500 per incident.

Section 4. Section 395.3011, Florida Statutes, is created to read:

395.3011 Billing and collection activities.—

(1) As used in this section, the term "extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

(a) Selling the individual's debt to another party.

(b) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(c) Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.

(d) Actions that require a legal or judicial process, including, but not limited to:

1. Placing a lien on the individual's property;

2. Foreclosing on the individual's real property;

3. Attaching or seizing the individual's bank account or any other personal property;

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

(2) A facility may not engage in an extraordinary collection action against an individual to obtain payment for services:

(a) Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance.

(b) Before the facility has provided the individual with an itemized statement or bill.

(c) During an ongoing grievance process as described in s. 395.301(6) or an ongoing appeal of a claim adjudication.

(d) Before billing any applicable insurer and allowing the

insurer to adjudicate a claim.

(e) For 30 calendar days after notifying the patient in writing, by certified mail or by other traceable delivery method, that a collection action will commence absent additional action by the patient.

(f) While the individual:

1. Negotiates in good faith the final amount of a bill for services rendered; or

2. Complies with all terms of a payment plan with the facility.

Section 5. Paragraph (b) of subsection (1) of section 624.27, Florida Statutes, is amended to read:

624.27 Direct health care agreements; exemption from code.—

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

(b) "Health care provider" means a health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, ~~or~~ chapter 466, chapter 490, or chapter 491, or a health care group practice, who provides health care services to patients.

Section 6. Section 627.446, Florida Statutes, is created to read:

627.446 Advanced explanation of benefits.—

(1) As used in this section, the term "health insurer" means an authorized insurer issuing individual or group coverage under this chapter or a health maintenance organization issuing coverage through an individual or a group contract under chapter 641.

(2) Each health insurer shall prepare an advanced explanation of benefits upon receiving a patient estimate from a

facility pursuant to s. 395.301(1). The health insurer must provide the advanced explanation of benefits to the insured no later than 1 business day after receiving the patient estimate from the facility or, in the case of a service scheduled at least 10 business days in advance, no later than 3 business days after receiving such estimate.

(3) At a minimum, the advanced explanation of benefits must include detailed coverage and cost-sharing information pursuant to 42 U.S.C. s. 300gg-111 (2020) and the regulations and guidance adopted thereunder.

Section 7. Section 627.447, Florida Statutes, is created to read:

627.447 Disclosure of discounted cash prices.—A health insurer may not prohibit a provider from disclosing to an insured the option to pay the provider's discounted cash price for health care services. For purposes of this section, the term "discounted cash price" has the following meanings:

(1) With respect to a hospital facility, the term has the same meaning as provided in 45 C.F.R. s. 180.20. The term does not include the amount charged to an individual pursuant to a facility's financial assistance policy.

(2) With respect to a provider that is not a hospital, the term means the charge that is applied to an individual who paid for a health care service without filing an insurance claim.

Section 8. Paragraphs (b) and (c) of subsection (2), subsection (3), and paragraph (a) of subsection (4) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 627.446 ~~s. 624.603~~.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer provides ~~may provide~~ to an insured for choosing certain shoppable health care services under a shared savings incentive program, which ~~and~~ may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(3) A health insurer must ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer ~~that offers a shared savings incentive program~~ must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program and that participation by the insured is voluntary and optional.

(d) Publish on a web page easily accessible to insureds and to applicants for insurance a list of shoppable health care

services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services

offered by the health insurer.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 9. Paragraph (a) of subsection (4) of section 627.6648, Florida Statutes, is amended to read:

627.6648 Shared savings incentive program.—

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical expense for such purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

Section 10. Paragraph (a) of subsection (4) of section 641.31076, Florida Statutes, is amended to read:

641.31076 Shared savings incentive program.—

(4) A shared savings incentive offered by a health maintenance organization in accordance with this section:

(a) Is not an administrative expense for rate development or rate filing purposes and shall be counted as a medical

expense for such purposes.

Section 11. Paragraphs (a) and (j) of subsection (1) of section 475.01, Florida Statutes, are amended to read:

475.01 Definitions.—

(1) As used in this part:

(a) "Broker" means a person who, for another, and for a compensation or valuable consideration directly or indirectly paid or promised, expressly or impliedly, or with an intent to collect or receive a compensation or valuable consideration therefor, appraises, auctions, sells, exchanges, buys, rents, or offers, attempts or agrees to appraise, auction, or negotiate the sale, exchange, purchase, or rental of business enterprises or business opportunities or any real property or any interest in or concerning the same, including mineral rights or leases, or who advertises or holds out to the public by any oral or printed solicitation or representation that she or he is engaged in the business of appraising, auctioning, buying, selling, exchanging, leasing, or renting business enterprises or business opportunities or real property of others or interests therein, including mineral rights, or who takes any part in the procuring of sellers, purchasers, lessors, or lessees of business enterprises or business opportunities or the real property of another, or leases, or interest therein, including mineral rights, or who directs or assists in the procuring of prospects or in the negotiation or closing of any transaction which does, or is calculated to, result in a sale, exchange, or leasing thereof, and who receives, expects, or is promised any compensation or valuable consideration, directly or indirectly therefor; and all persons who advertise rental property

information or lists. A broker renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~. Where the term "appraise" or "appraising" appears in the definition of the term "broker," it specifically excludes those appraisal services which must be performed only by a state-licensed or state-certified appraiser, and those appraisal services which may be performed by a registered trainee appraiser as defined in part II. The term "broker" also includes any person who is a general partner, officer, or director of a partnership or corporation which acts as a broker. The term "broker" also includes any person or entity who undertakes to list or sell one or more timeshare periods per year in one or more timeshare plans on behalf of any number of persons, except as provided in ss. 475.011 and 721.20.

(j) "Sales associate" means a person who performs any act specified in the definition of "broker," but who performs such act under the direction, control, or management of another person. A sales associate renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 12. Paragraph (h) of subsection (1) of section 475.611, Florida Statutes, is amended to read:

475.611 Definitions.—

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

(h) "Appraiser" means any person who is a registered trainee real estate appraiser, a licensed real estate appraiser, or a certified real estate appraiser. An appraiser renders a professional service and is a professional within the meaning of s. 95.11(5)(b) ~~s. 95.11(4)(b)~~.

Section 13. Subsection (7) of section 517.191, Florida Statutes, is amended to read:

517.191 Injunction to restrain violations; civil penalties; enforcement by Attorney General.—

(7) Notwithstanding s. 95.11(5)(f) ~~s. 95.11(4)(f)~~, an enforcement action brought under this section based on a violation of any provision of this chapter or any rule or order issued under this chapter shall be brought within 6 years after the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 8 years after the date such violation occurred.

Section 14. Subsection (14) of section 768.28, Florida Statutes, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(14) Every claim against the state or one of its agencies or subdivisions for damages for a negligent or wrongful act or omission pursuant to this section shall be forever barred unless the civil action is commenced by filing a complaint in the court of appropriate jurisdiction within 4 years after such claim accrues; except that an action for contribution must be commenced within the limitations provided in s. 768.31(4), and an action for damages arising from medical malpractice or wrongful death must be commenced within the limitations for such actions in s. 95.11(5) ~~s. 95.11(4)~~.

Section 15. Subsection (4) of section 787.061, Florida

Statutes, is amended to read:

787.061 Civil actions by victims of human trafficking.—

(4) STATUTE OF LIMITATIONS.—The statute of limitations as specified in s. 95.11(8) or (10) ~~s. 95.11(7) or (9)~~, as applicable, governs an action brought under this section.

Section 16. This act shall take effect October 1, 2024.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6
Meeting Date

BI
Committee

SB 1640
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID MICA, Jr.

Phone

Address
Street

Email

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FL Hospital Assn

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 15, 2024

I respectfully request that **Senate Bill #1640**, relating to Payments for Health Care Services, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Jay Collins
Florida Senate, District 14

File signed original with committee office

S-020 (03/2004)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1640
FINAL ACTION: Favorable
MEETING DATE: Tuesday, February 6, 2024
TIME: 3:00—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
X		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting