2011 Legislative Summary

Jeff Atwater

Chief Financial Officer
State of Florida

Department of Financial Services

INTRODUCTION

This document is an overview of legislation passed by the Florida Legislature during the 2011 Regular Legislative Session affecting the Department of Financial Services.

Access to all bills, their final action, legislative staff analyses, floor amendments, bill history and Florida Statutes citations are available through the Internet. The Internet address for the Florida Legislature Online Sunshine web site is:

http://www.leg.state.fl.us

For additional information on legislation passed by the Florida Legislature you may contact the Office of Legislative Affairs at (850) 413-2863.

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SJR 2 – Health Care Services: If adopted by the voters at the 2012 General Election, this resolution will take effect January 3, 2013; by Budget Committee and Sen. Haridopolos and others.

This is a joint resolution proposing the creation of s. 28, Art. I of the Florida Constitution to preserve the freedom of Florida residents to provide for their own health care by:

- Prohibiting a law or rule from compelling a person or employer to purchase, obtain, or otherwise provide for health care coverage.
- Permitting a person or employer to pay directly for lawful health care services without being penalized or taxed.
- Permitting a health care provider to accept direct payment for lawful health care services without being penalized or taxed.
- Prohibiting a law or rule from abolishing the private market for health care coverage of any lawful health care service.

The joint resolution specifies that it does not affect certain health care services; prohibit care provided pursuant to worker's compensation law; affect laws or rules in effect as of March 1, 2010; affect the terms or conditions of any health care system, unless certain circumstances exist; or affect any general law passed by a two-thirds vote of the membership of each house of the legislature after the joint resolution has become effective.

The joint resolution also provides definitions for certain terms and includes a summary statement that is to be placed on the ballot for the next general election.

HB 59 – Service of Process: Ch. 11-159, LOF; effective July 1, 2011; by Rep. Julien and others.

The Department of Financial Services (DFS) made recommendations to streamline the service of process on its department and other agencies, since the current requirements are antiquated due to the introduction of safe electronic storage and filing over the last few years. This bill will significantly reduce paperwork and costs to the private sector, including small businesses. The impact is an approximately 2,000,000 reduction in paper pages currently required to be sent to DFS.

Specifically the bill:

- Allows persons to file one copy of process on certain statutory agents, rather than the current requirement of two, and allows for such copies to be retained electronically.
- Allows those serving process on the Chief Financial Officer to serve one copy, instead of the current requirement of three, and also allows the record to be retained electronically.

HB 97 – Health Insurance: Ch. 11-111, LOF; effective July 1, 2011; by Rep. Gaetz and others.

The bill prohibits any individual, group, or out-of-state group health insurance policy or health maintenance contract, purchased with any amount of state or federal funds through an exchange, from providing coverage for an abortion unless the pregnancy is the result of an act of rape or incest or in cases where a woman suffers from a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death.

The federal Patient Protection and Affordable Care Act (PPACA), which was signed into law on March 23, 2010, is designed to, among other provisions, create a health insurance "exchange" in each state for individuals and employers to obtain health coverage. The PPACA sets minimum standards for health coverage offered in the exchanges and provides premium tax credits and cost-sharing subsidies for eligible, low-income individuals who obtain coverage through exchanges. An exchange is not an insurer; however, it is designed to provide eligible individuals and businesses with access to health insurance coverage.

Under the PPACA, exchanges must be self-sufficient by 2015 and may charge assessments or user fees. If the U.S. Department of Health and Human Services (HHS) determines by January 1, 2013, that a state has opted-out of operating an exchange or that it will not have an exchange operational by January 1, 2014, the HHS shall operate an exchange in that state, either directly or through agreement with a non-profit entity.

This bill provides that such coverage in Florida is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied to the cost of the policy. The bill does not prohibit the purchase of separate coverage for abortion if that separate coverage is not purchased with any state or federal funds. The bill defines "state" to mean the State of Florida or any political subdivision of the state.

The bill's exceptions for abortion coverage in cases of rape or incest or in cases where the pregnant woman's life is certified by a physician to be in danger, are modeled after the federal "Hyde Amendment," which is the common name for a provision in the annual federal appropriations act for the HHS, the U.S. Department of Labor, and the U.S. Department of Education, which prevents Medicaid and any other programs under these departments from funding abortions, except for such cases described above. Provisions of the Hyde Amendment have been enacted into federal law in various forms since 1976.

HB 99 - Commercial Insurance Rates: Ch. 11-160, LOF; effective October 1, 2011; by Economic Affairs Committee, Insurance & Banking Subcommittee and Rep. Drake.

The bill allows five new types of commercial insurance to be exempt from the rate filing and approval process in current law. Thus, insurance companies writing these types of commercial insurance will not have to file with or obtain approval of the rates for these types of commercial insurance by the OIR before the insurer can charge the rate. The new types of commercial insurance exempted are:

- ***Fiduciary Liability***: Liability protection against the theft or misuse of funds for an entity involved in the management, investment and distributions of funds.
- ***General Liability***: Covers the legal liability for the death, injury, or disability of any human being, or for damage to property, irrespective of the legal liability of the insured.
- ***Nonresidential Property***: Covers a building, business personal property, and other surrounding property not used for residential purposes for loss or damage from a variety of perils, including but not limited to, fire, lightning, glass breakage, tornado, windstorm, hail, water damage, explosion, riot, civil commotion, rain or damage from aircraft or vehicles. The exemption for nonresidential property does not include collateral protection insurance. Collateral protection insurance is still subject to rate regulation by the OIR.
- ***Nonresidential Multiperil***: Packages two or more insurance coverages protecting an enterprise from various property and liability risk exposures.
- ***Excess Property***: Covers damage from property insurance perils above the policy limit of the primary property insurance policy.
- ***Burglary and Theft***: Covers property taken or destroyed by break-in and entering the policyholder's premises; burglary or theft; forgery or counterfeiting, fraud; and off-premises exposure.

The bill changes the rate filing and approval exemption for commercial motor vehicle insurance. Under current law, only commercial motor vehicle insurance covering a fleet of 20 or more vehicles is exempt from the rate filing and approval process. The bill exempts all commercial motor vehicle insurance from the rate filing and approval process, regardless of the number of vehicles the insurance covers, thus expanding the current exemption for commercial motor vehicle insurance.

The bill deletes some of the information required on the notice an insurer must give the OIR when the rate changes for commercial insurance exempt from rate filing. Insurers will no longer be required to provide the OIR the amount of insurance premium written during the prior year for the type or kind of insurance subject to the rate change, but will still be required to provide the name of the insurer, the type or kind of insurance subject to the rate change, and the average statewide rate change.

The type of data required to be retained by the insurer or rating organization to support the rate charged for commercial insurance not subject to a rate filing is changed by the bill. Insurers are required to retain "actuarial data" about the commercial risks, but are no longer required to retain "underwriting files, premiums, losses, and expense statistics." Additionally, the bill adds a two year retention period for the insurer or rating organization to retain the actuarial data supporting the rate charged. Current law does not specify a retention period.

Although the bill deletes current law allowing the OIR to obtain information about a commercial insurance rate not subject to the rate filing and approval process at the insurer's or rating organization's expense, the bill requires the insurer or rating organization to incur the cost of any examination of the rate charged by the OIR.

SB 146 – Criminal Justice: Ch. 11-207, LOF; effective June 21, 2011, except as otherwise provided; by Sen. C. Smith and others.

This bill creates the "Jim King Keep Florida Working Act," which requires state agencies and regulatory boards to submit to the Governor and certain legislative officers a report that outlines current disqualifying policies on the employment or licensure of ex-offenders and possible alternatives that are compatible with protecting public safety. The bill also provides that a state agency may not deny an application for a license, permit, certificate, or employment based solely on the applicant's lack of civil rights.

HB 155 – Privacy of Firearms Owners: Ch. 11-112, LOF; effective June 2, 2011; by Health & Human Services Committee; Criminal Justice Subcommittee and Rep. Brodeur and others.

The bill creates s. 790.338, F.S., entitled "Medical privacy concerning firearms," which prohibits licensed health care practitioners and health care facilities from intentionally entering any disclosed information concerning firearm ownership into a patient's health record if the information is not relevant to the patient's medical care or safety, or the safety of others. Additionally, licensed health care providers and health care facilities are:

- To refrain from inquiring, whether oral or written, about the ownership of firearms or ammunition unless the information is relevant to the patient's medical care or safety, or the safety of others.
- Prohibited from discriminating against a patient based upon whether patient exercises his or her constitutional right to own and possess firearms or ammunition.
- To respect a patient's right to own or possess a firearm and refrain from harassing a patient about firearm ownership during an examination.

The bill specifies that non-compliance by licensed health care practitioners and health care facilities constitutes grounds for disciplinary action under ss. 456.072 (2), and 395.1055, F.S. Patients are permitted to decline to answer or provide any information

concerning the ownership of a firearm and a decision not to answer does not alter existing law regarding a physician's authority to choose patients.

The bill provides an EMT or paramedic the authority to inquire in good faith, about the possession or presence of a firearm if they believe that it is relevant to the treatment of a patient during course and scope of a medical emergency or if the presence or possession of a firearm poses a threat of imminent danger to the patient or others.

Insurers issuing the types of policies regulated pursuant to Chapter 627 are prohibited from discriminating, denying coverage, or increase premiums on the basis that an insured or applicant possesses or owns a firearm or ammunition. However, insurers are allowed to consider the fair market value of firearms or ammunition when setting premiums for scheduled personal property coverage.

The bill amends the Florida's Patient's Bill of Rights and Responsibilities (s. 381.026, F.S.) specifying that:

- Health care providers and health care facilities should refrain from inquiring, whether oral or written, about the ownership of firearms or ammunition unless the information is relevant to the patient's medical care or safety, or the safety of others.
- Patients have the right to decline to answer or provide any information concerning the ownership of a firearm and a decision not to answer does not alter existing law regarding a physician's authority to choose patients.
- Health care providers and health care facilities are prohibited from discriminating against a patient based upon whether patient exercises his or her constitutional right to own and possess firearms or ammunition.
- Health care providers and health care facilities are to respect a patient's right to own or possess a firearm and refrain from harassing a patient about firearm ownership during an examination.

SB 170 – Electronic Filing and Receipt of Court Documents: Ch. 11-208, LOF; effective July 1, 2011; by Budget Subcommittee on Criminal & Civil Justice Appropriations, Judiciary Committee and Sen. Bennett.

This bill requires each state attorney and public defender to electronically file court documents with the clerk of the court and electronically receive court documents from the clerk of the court. The bill defines the term "court documents." The bill further expresses the expectation of the Legislature that the state attorneys and public defenders consult with specified entities in implementing the electronic filing and receipt process. The Florida Prosecuting Attorneys Association and the Florida Public Defender Association are required to report to the President of the Senate and the Speaker of the House of Representatives by March 1, 2012, on the progress made in implementing electronic filing through the Florida Courts E-Portal (statewide portal) or other portal for case types not yet approved for filing through the statewide portal.

The bill also provides for electronic procedures in administrative proceedings. The bill requires parties represented by attorneys in hearings held under the Division of Administrative Hearings and in the Workers' Compensation Appeals Program to file all documents electronically.

SB 224 – Local Government Accountability: Ch. 11-144, LOF; effective October 1, 2011; by Governmental Oversight & Accountability Committee and Senators Dean and Lynn.

This bill provides minimum budgeting standards for counties, county officers, municipalities, and special districts. The bill requires the budget of each county, municipality, special district, water management district, school district, and certain county officers to be posted on the government entity's website. The bill requires certain counties, municipalities, and special districts to file their annual financial report and annual financial audit report with the Department of Financial Services and the annual financial audit report with the Office of the Auditor General within nine months of the end of the fiscal year. This bill also amends the reporting process used by the Legislative Auditing Committee and the Department of Community Affairs to compel special districts to file certain required financial reports.

The bill further allows certain municipalities to levy and collect special assessments in order to fund certain special security and crime prevention services and facilities. If the costs of such services and facilities are funded by ad valorem taxes prior to the levy of the assessment, the bill requires the taxes to be abated annually thereafter in an amount equal to the full amount of the special assessment.

HB 277 – Sovereign Immunity: Ch. 11-113, LOF; effective July 1, 2011, and applies to causes of action accruing on or after that date; by Rep. Goodson.

This bill provides that the two year statute of limitations at s. 95.11(4), F.S., applies to wrongful death actions brought against the state or one of its agencies or political subdivisions instead of the four year statute of limitations provision contained in s. 768.28, F.S.

This bill requires the claimant present a tort claim in writing to the Department of Financial Services within 2 years after claim accrues if the claim is for wrongful death. The bill provides that if the Department of Financial Services does not act on the wrongful death claim within 90 days, the claim is deemed denied. The bill tolls the statute of limitations during the time the Department of Financial Services is considering medical malpractice claims and wrongful death claims.

<u>HB 331 – Firesafety</u>: Ch. 11-79, LOF; effective July 1, 2011; by Rep. Weinstein.

<u>State Fire Marshal</u>
The bill revises the powers and duties of the State Fire Marshal to require the State Fire Marshal to consult with the Department of Education regarding the adoption of rules pertaining to safety and health standards at educational facilities. In the event that a county does not employ or appoint a certified firesafety inspector, the bill requires the State Fire Marshal to take the place of the county, municipality, or independent special fire control district regarding firesafety inspections of educational property.

The bill deletes the requirement for the State Fire Marshal to compile each local report into one document for submission to the Legislature, Governor, Commissioner of Education, State Board of Education, and Board of Governors.

<u>Firesafety Inspectors</u>
The bill abolishes the classification of "special state firesafety inspector" as of July 1, 2013, with all certifications set to expire at midnight on June 30, 2013. The bill prohibits a special state firesafety inspector certificate from being issued after June 30, 2011. Special state firesafety inspectors may, however, be grandfathered in as full firesafety inspectors under the following conditions:

- If the inspector has at least five years of experience as of July 1, 2011, and passes the firesafety inspection examination prior to July 1, 2013;
- If the inspector does not have five years of experience as a special state firesafety inspector as of July 1, 2011, but takes an additional 80 hours of courses and passes the examination prior to July 1, 2013; or
- If the inspector has at least five years of experience, fails the examination, but takes 80 additional hours of courses, retakes, and passes the examination prior to July 1, 2013.

The bill prohibits a person who fails the course of study or the examination from performing any firesafety inspections required by law on or after July 1, 2013.

The bill redefines the term "firesafety inspector" as a person who is certified by the State Fire Marshal, pursuant to s. 633.081, F.S. Consequently, the bill requires all administration and enforcement of uniform firesafety standards to be conducted by firesafety inspectors certified by the State Fire Marshal under s. 633.081, F.S.

<u>Firesafety Inspections by District School Board</u>
The bill requires a board to appoint certified firesafety inspectors to conduct annual inspections on educational and ancillary plant property. The bill requires inspections to begin no sooner than one year after a building certificate of occupancy is issued. The applicable board must submit a copy of the report to the county, municipality, or independent special fire control district providing fire protection services within 10 business days after the inspection, unless immediate corrective action is required, due to life-threatening deficiencies. The entity conducting the fire safety inspection is required to certify to the State Fire Marshal that the annual inspection has occurred.

Inspections of Educational Property by Other Public Agencies

The bill authorizes annual firesafety inspections to be conducted on educational and ancillary plant property operated by a school board or public college. Such inspections are allowed to begin no sooner than one year after a building certificate of occupancy is issued and annually thereafter. Immediate corrective action is required by the county, municipality, or independent special fire control district in conjunction with the appointed fire official where life-threatening deficiencies are noted.

Inspection of Charter Schools Not Located on Board-owned or Leased Property

The bill authorizes a safety or sanitation inspection of any educational or ancillary plant to be conducted at any time by a state or local agency authorized or required to conduct such inspections by general or special law. The agency is required to submit a copy of the inspection report to the charter school sponsor.

The bill requires a firesafety inspection to be conducted each fiscal year on educational facilities not owned or leased by the board or a public college, in accordance with State Fire Marshal standards. Upon request, the inspecting authority is required to provide a copy of each firesafety report to the board in the district in which the facility is located. The inspector must include a corrective plan of action in the report, with prompt response for life-threatening deficiencies. If corrective action is not taken, the county, municipality, or independent special fire control district must immediately report the deficiency to the State Fire Marshal and the charter school sponsor. The bill also expressly extends the State Fire Marshal's enforcement authority to charter school educational facilities and property.

Inspection of Public Postsecondary Education Facilities

The bill requires inspections of public college facilities, including charter schools located on board-owned or board-leased facilities or otherwise operated by public college boards, to comply with the Florida Fire Prevention Code, as adopted by the State Fire Marshal. Local amendments to the provisions of the code relating to such inspections are prohibited. An annual inspection by an inspector certified under s. 633.081, F.S., and a corrective plan of action are required by the bill. After the required firesafety inspection, the inspecting authority is required to develop a plan of action to correct each deficiency identified. The public college must provide a copy of the report to the appropriate county, municipality, or independent special fire control district. Firesafety inspections of state universities must comply with the Florida Fire Prevention Code. If a school board, public college board, or charter school does not take corrective action, the bill requires the inspecting authority to immediately report the deficiency to the State Fire Marshal.

Each board must provide for periodic inspection of proposed educational plants to ensure that the construction complies with the Florida Building Code and the Florida Fire Prevention Code, in addition to the currently mandated State Requirements for Educational Facilities. Also, to administer and enforce such codes, the bill allows each board to employ a fire official and such other inspectors who have been certified by the

State Fire Marshal, in addition to the currently authorized chief building official and such other inspectors who have been certified pursuant to chapter 468, F.S.

Approval of New Construction and Site Plans

The bill requires local boards to submit for approval new facility site plans to the county, municipality, or independent special fire control district, and outlines the process for compliance and informal appeal. A minimum of one copy of the site plan for each new facility or addition exceeding 2,500 square feet must be provided to the county, municipality, or independent special fire control district providing fire-protection services to the facility. The county, municipality, or independent special fire control district is allowed to review each site plan for compliance with Florida Fire Prevention Code relating to fire department access roads, fire-protection system connection locations, and fire hydrant spacing. Site plans are not subject to local amendments, and reviews must be performed at no charge to the school board or public college. The bill requires that the site plan be deemed approved within 15 days of receipt unless the local county, municipality, or independent special fire control district submits in writing, to the board appointed fire official, the deficiencies identified with reference to the Florida Fire Prevention Code. If there is disagreement between the board appointed inspector and the local county, municipality, or independent special fire control district official, then either party may refer it to the State Fire Marshal who has final authority.

Before the commencement of any new construction, renovation, or remodeling, the bill requires the school board to approve, or cause to be approved, construction documents for compliance with the Florida Building Code and the Florida Fire Prevention Code. Additionally, the school board must ensure compliance with all firesafety codes by contracting with a firesafety inspector certified by the State Fire Marshal. Furthermore, a certificate of occupancy may not be issued until the board, through its designated certified building official, has determined that the building or structure and its site conditions comply with all applicable statutes and rules. The method of compliance as chosen by the board must be documented and maintained as part of the construction record file. Upon request by the local county, municipality, or independent special fire control district, the board must provide reasonable access to all construction documents.

HB 395 – University of Florida J. Hillis Miller Health Center/Sovereign Immunity: Ch. 11-114, LOF; effective July 1, 2011 and shall apply to causes of action accruing on or after July 1, 2011; by K-20 Competitiveness Subcommittee and Rep. O'Toole.

The bill provides that Shands Teaching Hospital and Clinics, Inc.; Shands Medical Center, Inc.; and Shands Jacksonville HealthCare, Inc.; and any not-for-profit subsidiary which directly delivers health care services "shall be conclusively deemed corporations primarily acting as instrumentalities of the state" for purposes of sovereign immunity.

SB 408 – Property and Casualty Insurance: Ch. 11-39, LOF; effective May 17, 2011; by Rules Committee, Budget Subcommittee on General Government Appropriations, Banking & Insurance Committee and Senators Richter and Hays.

Time Limits for Claims and Statute of Limitations
The bill places time limits for bringing a hurricane or sinkhole claim and also creates a statute of limitations for bringing a breach of contract property insurance action in court. A claim, supplemental claim, or reopened windstorm or hurricane claim must be given to the insurer within 3 years after the hurricane first makes landfall or the windstorm causes covered damage. An initial, supplemental or reopened sinkhole claim must be given to the insurer within 2 years after the policyholder knew or reasonably should have known about the sinkhole loss. The bill also enacts a 5 year statute of limitations for bringing an action for the breach of a property insurance contract that runs from the date of loss.

Florida Hurricane Catastrophe Fund
The bill requires the Florida Hurricane Catastrophe Fund (Cat Fund) to provide reimbursement for all incurred losses, including amounts paid as fees on behalf of the policyholder. However, the bill also specifies a number of losses that are excluded from payment.

Insurance Capital Build-Up Incentive Program
The bill authorizes the State Board of Administration (Board) and private market insurers to renegotiate the terms of a surplus note issued pursuant to the Insurance Capital Build-Up Incentive Program before January 1, 2011. If the insurer agrees to accelerate the payment period of the note by at least 5 years, the Board must agree to exempt the insurer from the premium-to- surplus ratios required by statute. If the insurer agrees to accelerate the payment period for less than 5 years, the Board may agree to an appropriate revision of the premium-to-surplus ratios after consulting with the Office of Insurance Regulation, subject to a minimum writing ratio of net premium to surplus of at least 1 to 1 or of gross premium to surplus of at least 3 to 1.

Surplus Requirements
The bill raises the surplus requirements for insurers transacting residential property insurance that are not a wholly owned subsidiary of an insurer domiciled in another state. For a new insurer, the bill raises the surplus requirement from $5 million to $15 million. An existing insurer that holds a certificate of authority before July 1, 2011, must have a surplus of at least $5 million until June 30, 2016; from July 1, 2016 until June 30, 2021, a surplus of at least $10 million; and on or after July 1, 2021, a surplus of at least $15 million.

Public Adjusters
The bill limits public adjuster fees related to reopened or supplemental claims to a maximum of 20 percent of the reopened or supplemental claim payment. The bill also limits public adjuster fees to 20 percent of an insurance claim payment made by the insurer more than one year after events that are the subject of a declaration of a state of emergency by the governor. A public adjuster fee related to a policy issued by Citizens

Property Insurance Corporation may not exceed 10 percent of the additional amount actually paid in excess of the amount originally offered by Citizens on the claim.

Public adjusters are prohibited from making deceptive or misleading advertisements or solicitations. Written solicitations must include a disclaimer notifying the consumer that a solicitation is being made. A public adjuster contract related to a property and casualty insurance claim must contain the full name of the public adjuster and public adjusting firm, the business address, license number, and other specified information.

Public adjusters must give prompt notice of a property loss claim to the insurer and include with the notice the public adjuster's employment contract. The public adjuster must also ensure that the insurer has access to inspect the property, can interview the insured directly about the loss and claim, and allow the insurer to obtain information necessary to investigate and respond to the claim. The insurance company's adjuster or other persons acting on the insurer's behalf must provide at least 48 hours notice before scheduling an inspection of the property or a meeting with the claimant. The insurer also must allow the public adjuster to be present during the insurer's in-person meetings with the insured.

The bill requires licensed contractors to be licensed as a public adjuster in order to adjust a claim on behalf of the insured.

Rate Standards

The bill requires property insurance rate filings to be submitted via the "file and use" method until May 1, 2012. In a "file and use" rate filing the insurer must receive approval from the Office of Insurance Regulation before implementing the insurer's proposed rate.

Residential property insurers are authorized to make a separate rate filing limited solely to an adjustment of its rates for reinsurance and financing products used as a replacement for reinsurance. The rate filing may not result in a premium increase of more than 15 percent for an individual policyholder and must be approved or disapproved by the Office of Insurance Regulation within 45 days. The OIR retains the authority to deny the filing if the proposed rate is excessive, inadequate, or unfairly discriminatory. An insurer may make only one such filing per 12-month period. The procedure created by the bill expands a provision in current law that authorizes a 10 percent rate increase per policyholder that is solely based on reinsurance that replaces Temporary Increase in Coverage Limits reinsurance from the Florida Hurricane Catastrophe Fund.

The bill specifies that that the sworn certification of a property insurance rate filing is not rendered false if the insurer provides the Office of Insurance Regulation with additional information pursuant to a request from the Office. The insurer's actuary responsible for providing the additional information must provide an additional sworn certification.

Citizens Property Insurance Corporation

The bill renames the Citizens "high risk" account the "coastal" account.

Under current law, Citizens is authorized to offer policies that provide coverage only for the peril of wind for risks located within the coastal account. The high risk area of the coastal account consists of areas that were eligible for coverage in the Florida Windstorm Underwriting Association, essentially coastal areas at high risk for a hurricane. The bill repeals the requirement to reduce the high-risk area after December 1, 2010, if necessary to reduce the probable maximum loss attributable to wind-only coverages to 25 percent below the "benchmark" for the high-risk area, which is defined in statute as the 100-year probable maximum loss for the Florida Windstorm Underwriting Association based on its November 30, 2000 exposures. The bill also repeals a requirement to reduce the high-risk area after February 1, 2015, by 50 percent below the benchmark. The requirement that the Citizens board issue an annual report showing the reduction or increase in the 100-year probable maximum loss attributable to wind only coverages and the quote share program is also repealed.

The bill specifies that Citizens may not levy regular assessments until the full Citizens policyholder surcharge has been levied. The bill also specifies that the Citizens policyholder surcharge must be paid upon cancellation, termination, or renewal of an existing policy or upon issuance of every new policy issued within 12 months after the surcharge is levied or the time needed to fully collect the policyholder surcharge.

As of January 1, 2012, Citizens must require agents to obtain from applicants for coverage a signed Acknowledgment of Potential Surcharge and Assessment Liability form. The form details that Citizens policyholders are subject to a Citizens policyholder surcharge of up to 45 percent of premium and emergency assessments.

Citizens policies issued or renewed on or after January 1, 2012, which cover sinkhole loss may not include coverage for losses to appurtenant structures, sidewalks, decks, or patios that are caused by sinkhole activity. Citizens must exclude such coverage using a notice of coverage change, which may be included with the policy renewal.

Citizens Board of Governors must commission an independent third-party consultant with insurance company management expertise to prepare a report and make recommendations on the costs and benefits of outsourcing policy issuance and service functions to private servicing carriers. The report must be completed and submitted to the Citizens board by July 1, 2012. The board must subsequently develop a plan to implement the consultant's report and submit the plan to the Financial Services Commission for review, modification, and approval. Upon the commission's approval of the plan, the Citizens board must begin implementing the plan by January 1, 2013.

Members of the Citizens Board of Governors with insurance experience are deemed to be within the exception in s. 112.313(7)(b), F.S., that allows a public officer to practice a particular profession or occupation when required or permitted by law or ordinance. The bill also provides procedures for board members who have a conflict of interest regarding a particular matter. A Citizens board member may not vote on any measure that would inure to the gain or loss of the board member; the board member's corporate principal or the parent or subsidiary of the corporate principal; or the relative or business associate of

the board member. A board member with a conflict must publicly state his or her interest in the matter prior to the vote being taken. The board member must also provide written disclosure of the conflict within 15 days after the vote, and the disclosure must be included in the minutes of the board meeting and available as a public record.

Notice of Cancellation

The bill revises the notice of cancellation, nonrenewal or termination requirements for personal lines and commercial lines residential property insurance policies. At least 120 days notice must be given to a named insured whose residential structure has been insured by the insurer or its affiliate for at least 5-years. Under current law 180 days notice must be provided for the cancellation, nonrenewal, or termination of such policies.

The bill authorizes the nonrenewal of a policy that covers both a home and a motor vehicle for any reason applicable to either the property or motor vehicle insurance, so long as the insurer provides 90 days notice of the nonrenewal. The notice of cancellation requirement for a Citizens policy that has been assumed by an authorized "take out" insurer is reduced to 45 days. The bill also authorizes an insurer to cancel or nonrenew a property insurance policy if the Office of Insurance Regulation finds that the early cancellation is necessary to protect the best interests of the public or policyholders. The Office may base its finding upon the financial condition of the insurer, the insurer's lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The nonrenewal may be conditioned upon the insurer being placed under administrative supervision or to the appointment of a receiver.

Notice of Change in Policy Terms

The bill authorizes insurers to renew a property and casualty insurance policy under different policy terms by providing to the policyholder a written "Notice of Change in Policy Terms" instead of a written "Notice of Non-Renewal." The Notice must be titled "Notice of Change in Policy Terms," give the insured written notice of the change, and be enclosed with the written notice of renewal premium. The insured is deemed to have accepted the change in policy terms upon the insurer's receipt of the premium payment for the renewal policy. If the insurer fails to provide the Notice of Change in Policy Terms the original policy terms remain in effect.

Replacement Cost Coverage

The bill modifies how insurers must pay dwelling or personal property losses on a replacement cost basis. For a dwelling loss, the insurer must initially pay the actual cash value, minus the deductible. Subsequently the insurer must pay any amounts necessary to perform repairs as work is performed. If a total loss of a dwelling occurs, the insurer must pay the entire replacement cost coverage without holdback of depreciation in value pursuant to the Valued Policy Law.

For personal property losses insured on a replacement cost basis, the insurer must offer two claim payment options. The first option requires the insurer to pay the replacement cost without holdback of depreciation, regardless of whether the insured replaces the property. The second option allows the insurer to limit the initial payment to the actual

cash value of the personal property to be replaced. To receive payment from the insurer for the full replacement value of the personal property, the insured must provide a receipt for the replaced property to the insurer. A policy authorizing the insurer to require replacement of personal property prior to paying the full replacement cost must provide the policyholder with a premium credit or discount and the insurer must provide clear notice of the payment process before the policy is bound.

<u>Sinkhole and Catastrophic Ground Cover Collapse Insurance</u>

The bill enacts numerous revisions and clarifications to ss. 627.706-627.7074, F.S., governing sinkhole and catastrophic ground cover collapse insurance. The bill authorizes insurers to restrict catastrophic ground cover collapse and sinkhole loss coverage to the principal building as defined in the insurance policy. The bill also allows an insurer to require a property inspection prior to issuing sinkhole loss coverage. The bill clarifies that additional living expense coverage is only available pursuant to a sinkhole loss if there is structural damage to the covered building.

The bill changes the definition of "sinkhole loss," primarily by creating a statutory definition of "structural damage." A sinkhole loss is defined in statute as structural damage to the covered building, including the foundation, caused by sinkhole activity. The bill creates a detailed definition of "structural damage" for purposes of determining whether a sinkhole loss has occurred. The definition specifies five distinct types of damage that constitute structural damage. Each type of damage is tied to standards contained in the Florida Building Code or used in the construction industry. Accordingly, in order for the policyholder to obtain policy benefits for sinkhole loss, the insured structure must sustain structural damage as defined by the bill that is caused by sinkhole activity.

Investigation of Sinkhole Claims – The bill creates a substantially new process for an insurer's investigation of a sinkhole claim. The process requires the insurer to determine whether: (1) the building has incurred structural damage that (2) has been caused by sinkhole activity. Coverage for sinkhole loss is not available if structural damage is not present or sinkhole activity is not the cause of structural damage. The new process is as follows:

- *Initial Inspection & Structural Damage Determination*: Upon receipt of a claim for sinkhole loss, the insurer must inspect the policyholder's premises to determine if there
- has been structural damage which may be the result of sinkhole activity. This inspection will often require the insurer to retain a professional engineer to evaluate whether the insured building has incurred structural damage as defined by statute.
- *Sinkhole Testing Initiated by the Insurer*: The insurer is required to engage a professional engineer or professional geologist to conduct sinkhole testing pursuant to s. 627.7072, F.S., if the insurer confirms that structural damage exists and is either unable to identify a valid cause of the structural damage or discovers that the structural damage is consistent with sinkhole loss. If coverage is excluded

under the policy even if sinkhole loss is confirmed, then the insurer is not required to conduct sinkhole testing.

- *Notice to the Policyholder*: The bill maintains the requirement that the insurer must provide written notice to the policyholder detailing what the insurer has determined to be the cause of damage (if the determination has been made) and a statement of the circumstances under which the insurer must conduct sinkhole testing. The policyholder must also be notified of his or her right to demand sinkhole testing and the circumstances under which the policyholder may incur costs associated with testing.
- *Authorization to Deny Sinkhole Claim*: Insurers may continue to deny the claim upon a determination that there is no sinkhole loss.
- *Policyholder Demand for Sinkhole Testing*: The bill specifies that the policyholder may demand sinkhole testing in writing within 60 days after receiving a claim denial if the insurer denies the claim without performing sinkhole testing and coverage would be available if a sinkhole loss is confirmed (i.e. the claim denial was not issued due to policy conditions or exclusions of coverage and instead was based the failure of the loss to meet the definition of sinkhole loss). However, if the policyholder requests such testing, it must pay the insurer 50 percent of the sinkhole testing costs up to $2,500. If the requested testing confirms a sinkhole loss the insurer must reimburse the testing costs to the policyholder.

Payment of Sinkhole Claims – The insurer continues to be required to pay to stabilize the land and building and repair the foundation upon the verification of a sinkhole loss. Payment shall be made to conduct such repairs in accordance with the recommendations of the professional engineer retained by the insurer under s. 627.707(2), F.S. The bill also clarifies that the insurer is required to give notice to the policyholder regarding payment of the claim.

The bill revises the statutory authorization specifying that the insurer may limit payment to the actual cash value of the sinkhole loss not including below-ground repair techniques until the policyholder enters into a contract for the performance of building stabilization repairs. The bill requires the contract for below-ground repairs to be made in accordance with the recommendations set forth in the insurer's sinkhole report issued pursuant to s. 627.7073, F.S., and entered into within 90 days after the policyholder receives notice that the insurer has confirmed coverage for sinkhole loss. The time period is tolled if either party invokes neutral evaluation. Stabilization and all other repairs to the structure and contents must be completed within 12 months after the policyholder enters into the contract for repairs unless the insurer and policyholder mutually agree otherwise, the claim is in litigation, or the claim is in neutral evaluation, appraisal or mediation.

The bill specifies that if a covered building suffers a sinkhole loss or catastrophic ground cover collapse, the insured must repair such damage in accordance with the insurer's professional engineer's recommended repairs. However, if repairs cannot be completed within policy limits, the insurer has the option to either pay to complete the recommended repairs or tender policy limits.

Prohibition Against Rebates – The policyholder is prohibited from accepting a rebate from a person performing sinkhole repairs. If the policyholder does receive a rebate, coverage under the insurance policy is rendered void and the policyholder must refund the amount of the rebate to the insurer. Furthermore, a person who offers a rebate commits insurance fraud punishable as a third degree felony as provided in s. 775.082, F.S. (up to 5 years imprisonment), s. 775.083, F.S. (up to a $5,000 fine), and s. 775.084, F.S. (for a habitual felony offender up to 10 years imprisonment with no eligibility for release for 5 years).

Nonrenewal of Policy Due to Sinkhole Claims – The circumstances that allow an insurer to nonrenew a policy on the basis of filing a sinkhole claim are modified. The policy may only be nonrenewed if the insurer makes payments for sinkhole loss that equal or exceed policy limits for damage to the covered building or the policyholder does not repair the structure in accordance with the engineering recommendations.

Sinkhole Testing Reports – The bill requires a sinkhole testing report to verify whether the structural damage to the covered building has been identified within a reasonable professional probability.

Filing of Reports With The Clerk of Courts – In addition to filing the sinkhole testing report with the Clerk of Court after paying a sinkhole loss claim, the bill requires the insurer to also file the neutral evaluator's report (if any), a copy of the certification indicating that stabilization has been completed (if applicable), and the amount of the claim payment. The policyholder must file a copy of any sinkhole report prepared on behalf of the policyholder as a precondition to accepting a sinkhole loss payment.

Certification of Proper Completion of Sinkhole Repairs – Once building stabilization or foundation repairs of a sinkhole loss are completed, the professional engineer responsible for monitoring the repairs must issue a report to the property owner detailing the repairs performed and certifying that the repairs were performed properly. The professional engineer must file with the Clerk of Court a copy of the report and certification, the legal description of the real property, and the name of the county clerk of court.

Neutral Evaluation of Disputed Sinkhole Claims – The bill specifies that neutral evaluation must determine causation (whether a sinkhole loss has occurred and, if so, whether the observed damage was caused by sinkhole activity); all methods of stabilization and repair both above and below ground; the costs for stabilization and all repairs; and all information needed to determine whether a sinkhole loss has been verified and render an opinion on all matters at dispute in the neutral evaluation.

The neutral evaluator must be provided with information necessary to perform his or her duties. The bill requires that the neutral evaluator must be allowed reasonable access to the interior and exterior of the insured structures to be evaluated or for which a claim has been made. The policyholder must provide the neutral evaluator with all reports initiated on behalf of the policyholder that confirm a sinkhole loss or dispute the insurer's sinkhole

testing report. Such materials must be provided prior to the neutral evaluator's physical inspection of the property.

The bill revises the procedures and time frames for conducting the neutral evaluation. The parties are provided 14 business days to agree to a neutral evaluator. If an agreement cannot be reached, the Department of Financial Services (DFS) shall appoint a certified neutral evaluator. Each party may disqualify two neutral evaluators without cause; a reduction from 3 disqualifications under current law. The neutral evaluator has 14 business days after the referral to notify the parties of the date, time and place of the neutral evaluation conference; an increase from 5 business days in current law. The neutral evaluator must make a reasonable effort to hold the conference within 90 days after the DFS has received the request for neutral evaluation. Failure to conduct the conference within 90 days does not invalidate either party's right to neutral evaluation. Current law requires that the neutral evaluation conference be held within 45 days. The neutral evaluator's report must be provided to the parties within 14 days after the completion of the neutral evaluation conference. A court proceeding related to the neutral evaluation must be stayed until 5 days after the filing of the neutral evaluator's report with the court.

If the neutral evaluator is not qualified to determine a disputed issue, he or she may enlist the assistance of another certified neutral evaluator, a professional engineer or professional geologist who is not a certified neutral evaluator, or a licensed general contractor to provide an opinion on that issue. Such person may be disqualified for cause in the same fashion as a neutral evaluator. The neutral evaluator may also request that the entity that performed the sinkhole investigation perform additional and reasonable testing that the neutral evaluator deems necessary.

If the insurer agrees to comply with the neutral evaluator's report, payments shall be made in accordance with the terms of the applicable insurance policy and s. 627.707(5), F.S.

The bill also makes the following changes related to the neutral evaluation process:

- Specifies that neutral evaluation does not invalidate an insurance policy's appraisal clause.
- Allows the parties to disqualify a neutral evaluator for cause based on specified familial or professional relationships.
- Requires admission of the neutral evaluator's oral testimony and full report in any action, litigation or proceeding related to the claim.
- Specifies that the actions of the insurer in neutral evaluation are not a confession of judgment or an admission of liability.
- Deems neutral evaluators agents of the Department of Financial Services and grants them immunity from suit pursuant to s. 44.107, F.S.

Legislative Intent – The bill states that the clarifications and revisions to ss. 627.706-627.7074, F.S., are intended to reduce the number and cost of sinkhole claims and disputes, increase reliance on scientific or technical determinations relating to sinkhole

claims, and ensure that repairs are made in accordance with scientific and technical determinations and insurance claims payments.

Other Provisions

The bill:

- Repeals the consumer advocate report card for property insurers.
- Repeals an obsolete requirement that the Office of Insurance Regulation develop a standard rating territory plan for residential property insurance by January 15, 2006.
- Authorizes the public hurricane loss projection model to charge a private market insurer fees for use of the model related to the reasonable costs associated with the operation and maintenance of the model.
- Repeals a requirement that the Office of Insurance Regulation develop a method to directly correlate property insurance hurricane mitigation discounts and credits with the Uniform Home Grading Scale.
- Clarifies that the requirement that an insurer must pay property insurance claim within 90 days of receiving notice of the claim applies to reopened and supplemental claims.
- Clarifies that inquiries about coverage on a property insurance contract are not claim activity unless a claim is filed by the policyholder which results in an insurer investigation of the claim.
- Repeals the electronic database of sinkhole activity.
- Specifies that the insurer may request at its own expense the verification a uniform hurricane mitigation verification provided to the insurer by the policyholder or policyholder's agent in addition to forms provided by an authorized mitigation inspector.
- Provides that all provisions of the act are severable from any provision that is held invalid.

HB 445 – Wellness or Health Improvement Programs: Ch. 11-167, LOF; effective July 1, 2011; by Rep. Ingram and others.

The bill specifies that an insurer or health maintenance organization (HMO) issuing a group or individual health benefit plan may offer a voluntary wellness or health improvement program and may encourage participation in the program by way of authorizing rewards or incentives. The bill authorizes insurers and HMOs to require a plan member to provide verification that the member's medical condition inhibits participation in the wellness or health improvement program. The bill requires that the reward or incentive must be disclosed in the insurance policy or certificate and that the bill does not prohibit insurers or HMOs from offering other incentives or rewards for adherence to a wellness or health improvement program otherwise authorized by state or federal law.

<u>HB 479 – Medical Malpractice</u>: Ch. 11-233, LOF; effective October 1, 2011, and applies to causes of action accruing on or after that date; by Judiciary Committee, Health Care Appropriations Subcommittee, Health & Human Services Access Subcommittee, Civil Justice Subcommittee and Rep. Horner and others.

The bill requires a physician, osteopathic physician, or dentist who provides expert testimony concerning the prevailing professional standard of care of a physician, osteopathic physician, or dentist to be licensed in this state or possess an expert witness certificate issued by the Department of Health. Florida licensed physicians and dentists and practitioners with an expert witness certificate will be subject to disciplinary action for offering false or misleading information as an expert witness.

The Board of Medicine is required to create by rule a standardized informed consent form setting forth the risks of cataract surgery. An executed informed consent form creates a rebuttable presumption that the physician properly disclosed the risks of cataract surgery in a civil action or administrative proceeding. Risks described in the signed informed consent form may not be classified as an "adverse incident" pursuant to s. 395.0197, F.S.

The bill requires an insurance policy or self-insurance policy for medical malpractice coverage to clearly state whether or not the insured has the exclusive right of veto of any admission of liability or offer of judgment. The bill repeals the requirement that a self-insurance policy or insurance policy for medical malpractice must authorize the insurer to make this decision without the permission of the insured medical provider if the action is within the policy limits.

The bill makes inadmissible all evidence related to an insurer's reimbursement policies or reimbursement determination regarding medical care provided to a plaintiff. The bill also prohibits the introduction of federal standards and regulations into evidence to establish that the medical provider breached the prevailing professional standard of care.

The bill requires a claimant to submit, along with the other required information, an executed authorization form as set forth in the bill, for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence. If the court finds that the authorization is not completed in good faith by the claimant, the court shall dismiss the claim and assess attorney's fees and costs.

A volunteer team physician at a sporting event sponsored by an elementary or secondary school, or a licensed practitioner who gratuitously conducts a medical evaluation of a student prior to the student participating on an interscholastic athletic team, is not liable for civil damages for the care, treatment, or evaluation unless it was conducted in a wrongful manner.

HB 567 – Judgment Interest: Ch. 11-169, LOF; effective July 1, 2011; by Judiciary Committee and Rep. Hudson.

This bill requires the Chief Financial Officer (CFO) to adjust the statutory rate of interest payable on judgments or decrees on a quarterly basis by averaging the discount rate of the Federal Reserve Bank of New York for the preceding 12 months, then adding 400 basis points to the averaged federal discount rate. The bill also provides that the interest rate at the time the judgment is obtained will be adjusted annually on January 1 of each year in accordance with the interest rate in effect on that date as set by the CFO until the judgment is paid, with the exception of certain judgments entered by the clerk of court.

HB 677 – Public Records/Office of Financial Regulation: Ch. 11-88, LOF; effective July 1, 2011; by Government Operations Subcommittee and Rep. Pilon.

Current law provides public record exemptions for the Office of Financial Regulation (OFR or office) for certain information obtained or created by OFR pursuant to its involvement in the charter, examination, or investigation of financial institutions. The exemptions vary among OFR's regulatory programs. Currently, the office does not have a public record exemption that would allow it to receive information from another state or federal government that is confidential or exempt pursuant to the laws of that state or pursuant to federal law.

The bill creates a public record exemption for the following information held by OFR:

- Information received from another state or federal regulatory, administrative, or criminal justice agency that is otherwise confidential or exempt pursuant to the laws of that state or pursuant to federal law.
- Information that is received or developed by OFR as part of a joint or multiagency investigation or examination.

The bill authorizes OFR to obtain and use information in accordance with the requirements imposed as a condition of participating in a joint or multiagency examination or investigation.

The bill provides for retroactive application of the exemption. It provides for repeal of the exemption on October 2, 2016, unless reviewed and saved from repeal by the Legislature. The bill also provides a statement of public necessity as required by the State Constitution.

<u>HB 723 – Reciprocity in Workers' Compensation Claims</u>: Ch. 11-171, LOF; effective July 1, 2011 and applies to any claim made on or after that date, regardless of the date of the accident; by Insurance & Banking Subcommittee and Representatives Weinstein and Dorworth.

Florida's Workers' Compensation Law, chapter 440, Florida Statutes, provides medically necessary treatment and, in some cases, compensation for disability to employees who suffer work-related injuries. Most states provide that workers' compensation insurance coverage in the employer's home state covers employees temporarily working in another state. Such laws authorize "extraterritorial" coverage.

At least 11 jurisdictions recognize another state's extraterritorial provisions under limited conditions. Specifically, this occurs when the other state also exempts out-of-state employees temporarily working within its borders (and their employers) from its workers' compensation law and provides that such employees (and employers) are subject to the law of the employer's home state. Laws that limit recognition of another state's extraterritorial provisions in this manner are said to provide "extraterritorial reciprocity," i.e., a state will honor other states' extraterritorial provisions as long as the other states honor its extraterritorial provisions. For example, California will not exercise jurisdiction over out-of-state employees temporarily working within its boundaries when certain conditions are met, if the employer's home state similarly would not exercise jurisdiction over California employees temporarily working there.

The bill provides for extraterritorial reciprocity under chapter 440, F.S. Employees who work for an employer in a state other than their primary state of employment for no more than 10 consecutive days or a maximum of 25 total days in a calendar year are considered to be "temporarily working" in that state. Florida employees injured while temporarily working in another state are to receive benefits under Florida's Workers' Compensation Law. Out-of-state employees injured while temporarily working in Florida (and their employers) are exempted from chapter 440, F.S., and will receive benefits under the law of their home state, which will be the employee's exclusive remedy, if the following conditions are met:

- The employer has furnished coverage under the workers' compensation law (or similar law) of the employer's home state that covers the employee's employment while in Florida.
- The extraterritorial provisions of Florida's Workers' Compensation Law are recognized in the employer's home state.
- Florida employees and employers are exempted from the workers' compensation law (or similar law) of the employer's home state for injuries that occur while Florida employees are temporarily working in the employer's home state.

Employees who have a claim in Florida and another state for the same injury are entitled to recover the amount of compensation due under chapter 440, F.S. Florida courts are required to take judicial notice of the construction of the laws of another jurisdiction if such construction is necessary in a legal proceeding.

A certificate from a duly authorized officer of the appropriate department of the employer's home state that the employer has provided extraterritorial coverage for its employees while temporarily working in Florida is prima facie evidence that the employer carries workers' compensation insurance.

The bill has no fiscal impact on state expenditures. To the extent that the bill provides for application of chapter 440, F.S., to Florida employees temporarily working in another state, the bill provides cost certainty for workplace injuries and decreases costs associated with retention of counsel with expertise in other states' workers' compensation laws.

HB 849 – Building Construction and Inspection: Ch. 11-222, LOF; effective July 1, 2011; by Economic Affairs Committee, Rulemaking & Regulation Subcommittee, Business & Consumer Affairs Subcommittee and Representatives Davis and Van Zant.

This bill exempts the Florida Building Code (Code) and the Florida Fire Prevention Code from being required to provide a statement of estimated regulatory costs and requires that proposed amendments to the foundation of the Code demonstrate a need for incorporation. Code amendments or modifications relating to the wind-resistance design of buildings and structures in the high-velocity hurricane zone of Miami-Dade and Broward Counties shall not expire and shall be carried forward to the next edition of the Code.

The bill redefines the term "sustainable building rating or national model building code" to include the International Green Construction Code and amends the membership composition requirements for the Florida Building Commission (Commission). The bill also expands the categories of persons who may be certified as qualified for licensure by endorsement as a home inspector and requires at least 2 hours of hurricane mitigation training to be included as part of a home inspector's continuing education requirements.

The bill repeals the exemption that permits Division I contractors to perform both the inspection and repairs on a home and authorizes individuals who are licensed as a landscape architect to submit landscape design plans to government agencies for approval.

This bill replaces one of the public lodging industry seats on the Department of Health advisory review board with a county or local building official and clarifies that the Habitat for Humanity exemption also applies to the rehabilitation of certain family residences.

Part II of ch. 533, F.S., relating to the accessibility requirements for handicapped persons is amended in order to revise references to the current 2010 ADA Standards for Accessible Design standards and to conform the Florida-specific provisions to those standards. A license classification for "glass and glazing contractor" is created.

The bill provides for state agency compliance with the 2011 version of the National Fire Protection Association standard (NFPA 58) for LP gas tank separation and replaces specific references to energy efficiency requirements with a reference to the Florida Energy Efficiency Code for Building Construction.

As a result of this bill, products advertised as hurricane windstorm or impact protection from wind-borne debris are required to be approved as such under Florida's product approval program and the Commission is prohibited from adopting rules that limit any of the statutory exceptions or exemptions to coastal construction control and erosion projection requirements.

The bill repeals current statutory provisions relating to requirements for scheduled increases in the energy performance of buildings subject to the Florida Energy Efficiency Code for Building Construction and requires certain public swimming pools and spas to be equipped with specified safety features.

SB 960 – Liquefied Petroleum Gas: Ch. 11-106, LOF; effective July 1, 2011; by Sen. Bennett.

The bill amends 527.06, F.S., to require the Dept. of Agriculture and Consumer Services (department), the Florida Building Code (FBC), and the Office of State Fire Marshal (OSFM) to enforce the same LP gas container separation distances as adopted in the 2011 version of the NFPA 58 gas code. By enacting this legislation, the footprint of cell phone towers and switching stations may be reduced, depending upon the tanks used to store the LP gas for the backup generators. The bill also provides for the statutory language regarding the 2011 version of the NFPA 58 gas code to expire once the department, the FBC, and the OSFM have adopted the 2011 version.

HB 993 – Rulemaking: Ch. 11-225, LOF; effective June 24, 2011; by Rules & Calendar Committee; Government Operations Subcommittee, Rulemaking & Regulation Subcommittee and Rep. Roberson.

This bill amends agency rulemaking procedures under the Administrative Procedure Act, and revises various provisions to align with legislative ratification requirements enacted in 2010. The bill also does the following:

- Requires agencies to include in each notice of rulemaking whether the proposed rule requires legislative ratification;
- Expressly includes legislative ratification in the description of factors controlling when an adopted rule takes effect;
- Resolves a timing conflict created by Chapter 2010-279, L.O.F., by restoring certain time deadlines to the pre-2010 provisions;
- Exempts emergency rulemaking, rules adopting federal standards, rules adjusting certain tolls, and rules implementing the 2011 Student Success Act from the requirements to prepare a statement of estimated regulatory costs and submission for legislative ratification;

- Provides a procedure for agencies to withdraw rules prior to becoming effective if the rule is invalidated by a final order or is timely submitted to the Legislature but not ratified in the regular session;
- Excludes from the ratification requirement the triennial update of the Florida Building Code and the triennial update of the Florida Fire Prevention Code;
- Creates a one-time process requiring all agencies to undertake a comprehensive review of the economic impact of their respective rules effective on or before November 16, 2010;
- Shifts the burden of proof in certain administrative proceedings to the nonapplicant third party petitioner;
- Permits the Legislature to conduct an internet-based public survey about the impact of regulations.

HB 1007 – Insurer Insolvency: Ch. 11-226, LOF; effective July 1, 2011; by Insurance & Banking Subcommittee and Representatives Bernard, Julien, Cruz and others.

Relating to the State Board of Administration

- The bill allows an insurer to request that the State Board of Administration renegotiate the terms of a surplus note issued before January 1, 2011 under the Insurance Capital Build-Up Incentive Program.
- The bill increases the surplus requirements from $100 million to $250 million for foreign insurers in order to receive credit for reinsurance ceded to these foreign insurers.
- The bill expands the list of nationally recognized statistical rating organizations that may be utilized to provide a secure financial rating.

Relating to Title Insurers

- The bill requires that after an order of rehabilitation has been entered, the receiver shall review the condition of the title insurer and file a plan of rehabilitation for approval with the court.
- The bill requires that policies on real property in this state issued by the title insurer in rehabilitation shall remain in force unless the receiver determines the assessment capacity provided by this section is insufficient to pay claims in the ordinary course of business.
- The bill allows policies on real property located outside the this state may be canceled as of a date provided by the receiver and approved by the court, if the state in which the property is located does not have statutory provisions to pay future losses on those policies.
- The bill requires the establishment of a claims filing deadline for policies on real property located outside this state that have been canceled.
- The bill requires the receiver to establish a proposed percentage of the remaining estate assets to fund out-of-state claims when policies have been canceled, with any unused funds being returned to the general assets of the estate.

- The bill requires the receiver to establish a proposed percentage of the remaining estate assets to fund out-of-state claims where policies remain in force.
- The bill requires that funds allocated to pay claims on policies located outside of this state shall be based on the pro rata share of premiums written in each state over each of the 5 calendar years preceding the date of an order of rehabilitation.
- The bill requires each title insurer shall be liable for an assessment to pay all unpaid title insurance claims and expenses of administering and settling those claims on real property in this state for any title insurer that is ordered into rehabilitation.
- The bill states that the Office of Insurance Regulation (office) shall order an assessment if requested by the receiver on an annual basis in an amount that the receiver deems sufficient for the payment of known claims, loss adjustment expenses, and the cost of administration of the rehabilitation expenses. The receiver shall consider the remaining assets of the insurer in receivership when making its request to the office. Annual assessments may be made until no more policies of the title insurer in rehabilitation are in force or the potential future liability has been satisfied. The office may exempt or limit the assessment of a title insurer if such assessment would result in a reduction to surplus as to policyholders below the minimum required to maintain the insurer's certificate of authority in any state.
- The bill requires that the assessments shall be based on the total of the direct title insurance premiums written in this state as reported to the office for the most recent calendar year. Each title insurer doing business in this state shall be assessed on a pro rata share basis of the total direct title insurance premiums written in this state.
- The bill requires that assessments be paid to the receiver within 90 days after notice of the assessment or pursuant to a quarterly installment plan approved by the receiver. Any insurer that elects to pay an assessment on an installment plan shall also pay a financing charge to be determined by the receiver.
- The bill requires that the office shall order an emergency assessment if requested by the receiver. The total of any emergency assessment, when added to any annual assessment in a single calendar year, may not exceed 3 percent of an insurer's surplus to policyholders as of the end of the previous calendar year or more than 10 percent of its surplus to policyholders over any consecutive 5-year period. The 10 percent limitation shall be calculated as the sum of the percentages of surplus to policyholders assessed in each of those 5 years.
- The bill allows the receiver to use the proceeds of an assessment to acquire reinsurance or otherwise provide for the assumption of policy obligations by another insurer.
- The bill requires that the receiver shall make available information regarding unpaid claims on a quarterly basis.
- The bill requires a title insurer in rehabilitation may not be released from rehabilitation until all of the assessed insurers have recovered the amount assessed either through surcharges collected or payments from the insurer in rehabilitation.
- The bill prohibits a title insurer in rehabilitation, for which an assessment has been ordered, from issuing any new policies until the insurer has been released

from rehabilitation and has received approval from the office to resume issuing policies.

- The bill prohibits officers, directors, and shareholders of a title insurer ordered into rehabilitation or liquidation from serving as an officer, director, or shareholder of another insurer authorized in this state unless the officer, director, or shareholder demonstrates to the office for a 2-year period immediately preceding the receivership that: his or her personal actions or omissions were not a significant contributing cause to the receivership; he or she did not willfully violate any order of the office; he or she did not receive directly or indirectly any distribution of funds from the insurer in excess of amounts authorized in writing by the office; the financial statements filed with the office were true and correct statements of the title insurer's financial contrition; he or she did not engage in any business practices which were hazardous to the policyholders, creditors, or the public; and he or she at all times acted in the best interests of the title insurer.
- The bill requires upon the making of any assessment, the office shall order a surcharge on each title insurance policy issued thereafter, which insures an interest in real property in this state. The office shall set the per transaction surcharge at an amount estimated to generate sufficient funds to recover the amount assessed over a period of not more than 7 years. The amount of the surcharge ordered under this section may not exceed $25 per transaction for each impaired title insurer. If additional surcharges are occasioned by additional title insurers becoming impaired, the office shall order an increase in the amount of the surcharge to reflect the aggregate surcharge.
- The bill states the party responsible for payment of title insurance premium, unless otherwise agreed between the parties, shall be responsible for the payment of the surcharge. No surcharge will be due or owing as to any policy of title insurance issued at the simultaneous issue rate. For all other purposes, the surcharge will be considered a governmental assessment to be separately stated on any settlement statement. The surcharge is not subject to premium tax or reserve requirements.
- The bill requires that a title insurer doing business in this state which wrote no premiums in the prior calendar year shall collect the same per transaction surcharge. Such surcharge collected shall be paid to the receiver within 60 days after receipt from the title agent or agency.
- The bill states that each title insurance agent, agency, or direct title operation shall collect the surcharge as to each title insurance policy written and remit those surcharges along with the policies and premiums within 60 days to the title insurer on whom the policy was written.
- The bill prohibits a title insurer from retaining more in surcharges for an ordered assessment than the amount of assessment that title insurer paid.
- The bill requires each title insurer collecting surcharges to promptly notify the office when it has collected surcharges equal to the amount of the assessments paid. The office shall notify all companies, including those collecting surcharges to cease collecting surcharges when notified that all assessments have been recovered.

- The bill requires that when filing each quarterly financial statement, a title insurer shall provide the office with an accounting of assessments paid and surcharges collected during the period. Any surcharges collected in excess of the amount assessed shall be paid to the Insurance Regulatory Trust Fund.

Relating to the Department of Financial Services

- The bill allows the Department of Financial Services to be named as an ancillary receiver of a non-Florida domiciled company in order to obtain records to adjudicate covered claims of policy holders in Florida.
- The bill provides for the State Risk Management Trust Fund to cover employees, officers, and agents at the department for liability under 31 U.S.C. s. 3713, relating to priority of claims paid by the department while acting as a receiver.
- The bill requires the Insurance Regulation Trust Fund to cover all unreimbursed costs when opening ancillary delinquency proceedings for the purposes of obtaining records.
- The bill further clarifies the department's power to obtain records from third-party administrators.

Relating to Florida's Insurance Guaranty Associations

- The bill makes changes to the Florida Insurance Guaranty Association (FIGA) and Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) statutes relating to the definition of "covered claims" rejected by another state's guaranty fund.
- The bill amends qualifications of FIGA and FWCIGA board members representing, or employed by, an insurer in receivership.
- The bill clarifies FIGA's obligation to pay valid claims after an independent review of policies and claims has been presented to it.

HB 1037 – Continuing Care Retirement Communities: Ch. 11-193, LOF; effective July 1, 2011; by Health & Human Services Quality Subcommittee; Health & Human Services Committee and Representatives Bembry, Passidomo and others.

Continuing Care Retirement Communities (CCRCs), also known as life-care facilities, are retirement facilities that furnish residents with shelter and health care for an entrance fee and monthly payments. In Florida, CCRCs are regulated by the Department of Financial Services, the Agency for Health Care Administration and the Office of Insurance Regulation (OIR); the latter primarily through chapter 651, F.S. The OIR authorizes and monitors a facility's operation as well as determines the facility's financial status and the management capabilities of its managers and owners. The OIR is also empowered to discipline a facility for violations of residents' rights. Currently there are 70 CCRCs in the state, which are home to approximately 25,000 residents.

The bill allows continuing care at-home contracts to be offered to consumers in Florida. Continuing care at-home contracts and programs allow seniors to receive services offered by a continuing care retirement center in their own homes while reserving the right to

shelter to be provided by the retirement center at a later date. Continuing care at-home contracts specify the exact services to be provided to an individual by a provider, in exchange for an initial fee and a recurring monthly premium. Continuing care at-home contracts provide seniors the flexibility of receiving services in their home until they are ready to move to a traditional continuing care retirement center.

The bill creates s. 651.057, F.S., establishing a new regulatory scheme for continuing care at-home contracts. The provisions of the bill closely reflect the provisions regulating continuing care contracts found throughout chapter 651, F.S. The bill also establishes criteria for providers seeking provisional certificates of authority and certificates of authority to offer continuing care at-home contracts. The bill provides the OIR with authority to regulate the issuance of provisional certificates of authority and certificates of authority, and to approve continuing care at-home contracts for use in Florida. The bill makes numerous conforming changes to reflect the provisions of the bill.

HB 1087 – Insurance: Ch. 11-174, LOF; effective July 1, 2011, except as otherwise provided; by Economic Affairs Committee and Rep. Holder.

In Florida, the Office of Insurance Regulation (OIR) regulates insurers and other risk-bearing entities. The Department of Financial Services (DFS) has regulatory authority over many insurance-related activities, including, but not limited to, insurance agents and agencies, investigation of insurance fraud, and the administration of the Workers' Compensation Law. The bill provides the following changes to these insurance-related activities:

Notification of the Cancellation, Nonrenewal, or Renewal of a Policy

The bill revises the policyholder notification requirements for an insurer in transactions involving the nonrenewal, renewal, or cancellation of workers compensation, employer liability, commercial liability, motor vehicle, or other property and casualty insurance coverage. The bill changes the designated person or persons an insurer is required to notify from the "named insured" to the "first-named insured" in transactions involving the nonrenewal, renewal, or cancellation of such.

Workers' Compensation Insurance

The bill allows for the use of a prepaid card for the provision of workers' compensation benefits to an injured employee if certain conditions are met. Currently, such benefits are payable by check or by direct deposit into the employee's account. The bill permits flexibility for insurers regarding the frequency of premium audits by providing that such audits are not required for coverage, except as provided by the insurance policy, by an order of the OIR, or at least once each policy period at the request of the insured. The bill provides that assessments for the Special Disability Trust Fund are determined on a calendar year basis rather than a fiscal year basis.

Certificate of Authority Requirements for Insurers
The bill allows insurers domiciled outside of the U.S., that cover only persons who are nonresidents of the U.S., to be exempt from the certificate of authority provisions if certain conditions are met. Currently, life insurers are provided an exemption if certain conditions are met.

Licensure of Agents and Agencies
The bill revises the requirements for disqualification of applicants convicted of certain crimes from agent and adjuster licensure by the DFS. The bill bars persons who commit specified felonies from applying for licensure and revises license waiting periods for other persons.

Motor Vehicle Insurance
The bill creates a civil penalty for motor vehicle insurance fraud authorizing civil fines of up to $5,000 for the first offense, $10,000 for the second offense, and $15,000 for third and subsequent offenses.

Service Warranty Associations
The bill exempts a service warranty company from licensure requirements if the service warranties are only offered, marketed, or sold to nonresidents of Florida, and meets other requirements.

Surplus Lines Insurance
The bill allows surplus lines insurance agents to place commercial insurance directly in the surplus lines market without requiring the agent to make a diligent effort to procure such coverage from an authorized insurer. The bill also requires the insured to sign a disclosure regarding surplus lines coverage.

HB 1121 – Financial Institutions: Ch. 11-194, LOF; effective July 1, 2011; by Insurance & Banking Subcommittee and Rep. Ingram.

The bill authorizes the Office of Financial Regulation (OFR) to appoint provisional directors if a bank or credit union lacks the minimum number of directors to meet statutory requirements, and appoint provisional executive officers if there is an insufficient number of qualified executive officers to operate the financial institution in a safe and sound manner. Current law does not provide for such provisional appointments.

The bill removes the requirement that the OFR conduct its own evaluation of each state-chartered bank at least once during each 36-month period, thereby reducing potential duplication of activities by federal regulators. It allows the OFR to enter into agreements with other appropriate state and federal regulatory agencies to facilitate the efficient utilization and coordination of resources in the examinations.

The bill also expands the actions that the OFR can take under an emergency order regarding a failing financial institution. These include:

- Authorizing the direct or indirect acquisition of control of the failing institution.
- Appointing provisional directors, executive officers, or other employees.
- Authorizing any other capital or liquidity restoration plan or action deemed prudent.

The bill authorizes the OFR to grant prior approval of a bank charter which would remain inactive until the investor(s) acquire a troubled institution. By granting preliminary approval of a "shelf charter", the pool of potential buyers for troubled institutions is expanded, potentially resulting in new equity capital available to bid on troubled institutions.

The bill provides for compliance with the Wall Street Reform and Consumer Protection Act which implements changes that affect the oversight and supervision of financial institutions. In doing so, it:

- Removes references to, or requirement for, reliance on credit ratings as regards a financial institution's investment of funds. It replaces those provisions with a requirement that financial institutions establish written policies and procedures to evaluate the risks and benefits associated with authorized investments.
- Requires state-chartered credit unions and banks to take into account potential liabilities and obligations resulting from derivatives transactions, repurchase agreements, securities lending and borrowing transactions, credit default swaps, and similar contracts when considering loans or lines of credit.
- Provides for de novo branching by an out-of-state bank and allows for establishment of additional branches by an out-of-state financial institution as though it was chartered in Florida,

The bill authorizes the OFR to approve special stock offering plans to assist undercapitalized banks in raising capital. Plans could include such things as stock splits, revaluations of par value, and creation of new classes of stock. In addition, the bill clarifies the definition and functions of a "banker's bank" to create uniformity with federal regulations.

HB 1125 – Health and Human Services: Ch. 11-195, LOF; effective July 1, 2011; by Health & Human Services Quality Subcommittee and Rep. Corcoran.

In 2008, the Florida Legislature created the Florida Health Choices Program (program). The program is designed to provide a centralized marketplace for the sale and purchase of health care products. These products would include, but are not limited to, health insurance plans, health maintenance organizations (HMOs) plans, prepaid services, service contracts, and flexible spending accounts. The bill makes the following changes to the program:

- Expands the products, vendors, employers, and individuals that may participate in the program;
- Streamlines and clarifies the process by which new products are approved and offered; and

- Requires the Office of Insurance Regulation (OIR) to approve risk-bearing products offered by the program.

The bill also contains the following provisions:

- Exempts specified Medicaid psychiatric facilities and Level III neonatal intensive care units from the certificate-of-need provisions if certain conditions are met;
- Revises the eligibility requirements for health flex plans by eliminating the requirement that an enrollee must be 64 years of age or younger; and
- Adds licensed orthotists and prosthetists to the current definition of "health care provider," under s. 766.202, F.S., for purposes of medical malpractice actions pursuant to ch. 766, F.S.

SB 1128 – Public Retirement Plans: Ch. 11-216, LOF; effective July 1, 2011; by Governmental Oversight & Accountability Committee, Budget Committee and Sen. Ring and others.

This bill increases the transparency of local pension plan data, and specifies other actions to address the sustainability of local pension plans. The bill does the following:

- Local plans' actuarial reports are required to include the present value of all benefits using a standard rate of return, to promote comparisons between plans;
- DMS is required to post on their website a five-year history of each plan's funded ratio, and local plans are required to link to this DMS website;
- Actuarial or cash surpluses in a local plan may not be used outside the plan;
- Local plans may not reduce contributions required to fund normal cost;
- For all local plans, accrued sick or annual leave may not be included in calculations of retirement benefits; overtime may be included, but is capped at 300 hours;
- With approval of the members, firefighter and police plans are allowed to increase member contributions without increasing member benefits;
- The bill changes the date in 1939 by which local law plans are deemed to be in compliance with Chapters 175 and 185;
- The bill creates a Task Force on Public Employee Disability Presumptions (includes one member employed by DFS who has relevant expertise in state risk management, appointed by the CFO) to study and make recommendations on statutory disability presumptions to the Governor, Chief Financial Officer and the Legislature by January 1, 2012;
- The DFS is to provide administrative support to the Task Force on Public Employee Disability Presumptions;
- The Department of Management Services is required to create a plan for providing standardized ratings for the financial strength of all local government defined benefit plans in Florida, and provide recommendations to the Governor, Chief Financial Officer and the Legislature in January 1, 2012.

HB 1193 – Health Insurance: Ch. 11-126, LOF; effective June 2, 2011; by Health & Human Services Quality Subcommittee and Rep. Hudson and others.

The bill prohibits compelling any person to purchase health insurance, with several exceptions. A person may be compelled to purchase health insurance only as a condition of:

- Public employment;
- Voluntary participation in a state or local benefit;
- Operating a dangerous instrumentality;
- Undertaking an occupation having a risk of occupational injury or illness;
- An order of child support; or
- Activity between private persons.

The bill expressly provides that its terms do not prohibit the collection of debts lawfully incurred for health insurance.

HB 1195 – Condominium, Cooperative, and Homeowners' Associations: Ch. 11-196, LOF; effective July 1, 2011; by Judiciary Committee, Economic Affairs Committee, Civil Justice Subcommittee and Representatives Moraitis and others.

This bill makes numerous changes relative to condominiums, cooperatives and homeowners' associations.

Specific to the department's enforcement of the Florida Fire Prevention Code, the bill provides that a condominium, cooperative, or multifamily residential building that is less than four stories is exempt from installing and maintaining a manual fire alarm system if the building has an exterior corridor providing a means of egress. This language is intended to clarify existing law.

SB 1204 – Joint Legislative Organization: Ch. 11-34, LOF; effective May 5, 2011; by Sen. Thrasher.

The bill moves the authorization for, and some of the duties of, the following entities from the Florida Statutes to the Joint Rules of the Florida Legislature: JLAC, JAPC, JPCO, OPPAGA, EDR, and OLS. Numerous technical and conforming changes are also made to the Florida Statutes.

Legislative Auditing Committee

The statutory authority creating the Joint Legislative Auditing Committee's in Section 11.40(1), F.S., is repealed. Under SCR 1202 (2011), JLAC is recreated in Rule 4 of the Joint Rules of the Florida Legislature and makes technical and conforming changes to the statutes.

Joint Administrative Procedures Committee
The enabling legislation concerning JAPC in Section 11.60, F.S., is deleted. Under SCR 1202 (2011), JAPC would be recreated in Rule 4 of the Joint Rules of the Florida Legislature along with many of the current statutory functions and duties. The bill creates Section 1.01(16), F.S., which defines the term "Administrative Procedures Committee" as a committee designated by joint rule of the Legislature or by agreement between the President of the Senate and the Speaker of the House of Representatives, to conform.

Committee on Public Counsel Oversight
The bill repeals Section 350.012, F.S., which provides for the creation of the Committee on Public Counsel Oversight and provides its statutory authority. The Committee on Public Counsel Oversight is recreated in Rule 4 of the Joint Rules of the Florida Legislature in SCR 1202 (2011) and makes technical and conforming changes to the statutes.

Office of Program Policy Analysis and Government Accountability
The bill deletes the statutory language creating OPPAGA in Section 11.51(1), F.S. Under SCR 1202 (2011), OPPAGA is recreated in Rule 3 of the Joint Rules of the Florida Legislature and makes technical and conforming changes to the statutes.

Office of Economic and Demographic Research
The Office of Economic and Demographic Research is created in Rule 3 of the Joint Rules of the Florida Legislature and the bill makes technical and conforming changes to the statutes.

Office of Legislative Services
The bill amends Section 11.147, F.S., to provide that OLS is designated as such by joint rule of the Legislature or by agreement between the President of the Senate and the Speaker of the House of Representatives and makes technical and conforming changes to the statutes.

Legislative Committee on Intergovernmental Relations
LCIR is eliminated by repeal of Section 11.70, F.S., containing LCIR's enabling provisions.

Additionally, the bill makes the following conforming and technical changes to the Florida Statutes:

- Amending Section 29.0085(1), F.S., by requiring certain revenues and expenditure statements be made in the form and manner prescribed by the Chief Financial Officer in consultation with the President of the Senate and the Speaker of the House of Representatives;
- Deleting the requirement in that Section that the Chief Financial Officer consult with LCIR; Section 112.313(9)(a), F.S., is amended to remove the executive director of the LCIR from the two year postemployment restriction on representing clients for compensation before the LCIR; The bill also deletes the requirement that a finding that a member of LCIR violated the Code of Ethics be

forwarded by the Commission on Ethics to the President of the Senate and the Speaker of the House of Representatives;

- Deleting the requirement in Section 163.055(4), F.S., that program providers annually submit information to the LCIR;
- Section 163.055(5), F.S., no longer requires the LCIR to assist the Chief Financial Officer in preparation of the requests for proposals, reviewing of each contract, or providing the Chief Financial Officer written advisory comments and recommendations;
- Removing a reference to LCIR in Section 163.55(5)(c), F.S., establishing the factors to be considered in reviewing contract proposals;
- No longer requiring the Chief Financial Officer to provide LCIR a copy of the decision to award a contract under Section 163.055(6), F.S.;
- Relieving LCIR's obligation under Section 163.055(9), F.S., to perform an annual performance review and provide its findings to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer;
- Requiring the Department of Community Affairs to provide a report to the President of the Senate and the Speaker of the House of Representatives instead of LCIR pursuant to Section 163.3245, F.S.;
- Replacing references to LCIR with references to the Office of Economic and Demographic Research in Section 166.021(9), F.S.;
- Providing that, pursuant to Section 166.021(9), F.S., the Office of Economic and Demographic Research will be responsible for providing certain reports to the President of the Senate and the Speaker of the House of Representatives instead of the Office of Trade, Tourism, and Economic Development; and,
- Deleting the requirement in Section 287.0943(2)(b), F.S., that the chairperson of LCIR, or his designee, serve as an *ex officio* member of the Minority Business Certification Task Force.

Joint Legislative Committee on Everglades Oversight
The bill eliminates the Joint Legislative Committee on Everglades Oversight by repeal of the enabling legislation in Section 11.80, F.S., and makes technical and conforming changes to the statutes.

Government Accountability Act
The bill eliminates the Legislative Sunset Review Committees and the Joint Legislative Sunset Committee by repeal of the entire Florida Government Accountability Act (Sections 11.901-11.920, Florida Statutes) and makes technical and conforming changes to the statutes.

Joint Select Committee – the Century Commission for a Sustainable Florida
The bill repeals Section 163.3247(4)(g), F.S., eliminating the Joint Select Committee to review the findings and recommendations of the Century Commission for a Sustainable Florida.

Technology Review Workgroup
The Technology Review Workgroup is eliminated by repeal of Section 216.0446, F.S. The bill also repeals the provisions concerning monitoring processes for information resources management projects pursuant to 282.322, F.S., and Section 216.163(2)(f), Florida Statutes. The bill amends Section 216.181, F.S., by removing the requirement that certain technology-related amendments must be reviewed by the Technology Review Workgroup.

Legislative Commission on Migrant and Seasonal Labor
The Legislative Commission on Migrant and Seasonal Labor is eliminated by repeal of Sections 450.201, 450.221, 450.231, and 450.241, F.S., and makes technical and conforming changes to the statutes.

The Council for Education Policy Research and Improvement
The bill deletes Section 1000.01(6), F.S., which creates the Council. The bill also deletes Section 1000.01(7), F.S., which provides that all personnel, unexpended balances of appropriations, and allocations of the Postsecondary Education Planning Commission are transferred to the Council.

Legislative Budget Commission
The bill contains a conforming change giving the Legislative Budget Commission authority to approve certain expenditures relating to information technology projects pursuant to Section 261.181(5), F.S.

Florida Department of Children and Families
The bill also makes conforming changes impacting the Florida Department of Children and Families. The bill amends Section 409.146(9), F.S., concerning the children and families client and management information system, by requiring the Department to report to the President of the Senate and the Speaker of the House of Representatives instead of the Joint Information Technology Resources Committee. The bill also deletes the portion of that Section requiring the Joint Information Technology Resources Committee to review the report and forward it to the appropriate committees in the Senate and the House of Representatives.

Southeastern Interstate Forest Fire Protection Compact
Currently, Section 590.33, F.S., provides that two of Florida's four members on the Southeastern Interstate Forest Fire Protection Compact Advisory Committee are required to be Legislators, one of which is from the Senate and the other from the House of Representatives. The bill amends that Section by specifying that the President of the Senate and the Speaker of the House of Representatives would each be responsible for designating one member.

<u>SB 1292 – Chief Financial Officer/Chart of Accounts</u>: Ch. 11-44, LOF, effective July 1, 2011; by Governmental Oversight & Accountability Committee, Budget Committee and Sen. Alexander.

The bill provides for the following:

- Beginning October 1, 2011, the Chief Financial Officer (CFO) will begin conducting workshops with state agencies, local governments, educational entities, and entities of higher education to gather information for the development of a uniform chart of accounts.
- The CFO will provide to the state agencies, local governments, educational entities and entities of higher education a draft chart of accounts by July 1, 2013.
- The CFO shall accept comments and input from state agencies, local governments, educational entities, and entities of higher education regarding the draft chart of accounts through November 1, 2013.
- By January 15, 2014, the CFO will present a report to the Governor, President of the Senate, and the Speaker of the House of Representatives recommending a uniform chart of accounts, which requires specific enterprise-wide information related to revenues and expenditures of state agencies, local governments, educational entities, and entities of higher education. The report will include the estimated cost of adopting and implementing a uniform enterprise-wide chart of accounts.

Note: $300,000 and three positions are authorized in budget to implement this legislation.

<u>SB 1314 - State Financial Matters</u>: Ch. 11-45, LOF; effective July 1, 2011; by Governmental Oversight & Accountability Committee, Budget Committee and Sen. Alexander.

This bill makes agencies more accountable in their contracting practices, and the Legislature more informed about the agencies' actions. Specifically, the bill:

- Defines a new budget category "Lease or lease/purchase of equipment." in s. 216.011, F.S. for the Legislature to better track expenditures.
- Requires each state agency to provide certain contract information in its Legislative Budget Request when granting a concession contract.
- Requires state agencies to identify the specific appropriation in the contract that will be used to make payment for the first year of the contract with a $5 million threshold, unless the Legislature specifically authorizes otherwise.
- The Act applies to contracts, contract amendments, contract extensions, or contract renewals which are executed on or after July 1, 2011.

SB 1316 – Loan Processing: Ch. 11-71, LOF; effective July 1, 2011; by Banking & Insurance Committee, Budget Subcommittee on General Government Appropriations and Sen. Detert.

The Housing and Economic Recovery Act of 2008 was enacted on July 30, 2008. Title V of this act is titled the "Secure and Fair Enforcement for Mortgage Licensing Act of 2008" or "S.A.F.E." The intent is to provide greater accountability and regulation of loan originators.

The Office of Financial Regulation is responsible for loan originator licensure and annual renewal. The process includes confirming completion of educational requirements, conducting criminal history background checks, and reviewing credit histories.

Normally, loan originators are prohibited from working for more than one mortgage broker or mortgage lender, whether as an employee or as an independent contractor. Current law provides an exception for "loan processors," who are individuals licensed as loan originators but only performing clerical or support duties. In that role, they may contract with or be employed by multiple companies. S.A.F.E. requires licensure of contract loan processors as loan originators.

The bill distinguishes between in-house loan processors, who will no longer require licensure, and contract loan processors. It requires direction and supervision of an in-house loan processor by a state-licensed loan originator.

While retaining the requirement that a good faith estimate be provided to an individual applying for a mortgage loan, as required by S.A.F.E., the bill removes the requirement for the borrower to sign and date the good faith estimate.

The bill codifies a requirement of S.A.F.E. that a mortgage lender submit reports of mortgage activity and financial information to the Nationwide Mortgage Licensing System and Registry.

The bill provides that real estate brokers are not subject to licensure as loan originators unless they are compensated by a lender, mortgage broker, or other loan originator, or by an agent of such parties.

SB 1346 – Obsolete Reference and Programs: Ch. 11-213, LOF; effective July 1, 2011; by Children, Families, & Elder Affairs Committee, and Commerce & Tourism Committee.

The bill amends or repeals 35 obsolete references to the former Department of Labor and Employment Security, or one of its former programs, and ten obsolete references to the Florida Department of Commerce still remaining in Florida Statutes. Additionally, it repeals or amends other statutes that have been identified that relate to programs related to or within a department that were obsolete prior to department abolishment.

Specific to the Department of Financial Services:

- Amends s. 414.40, F.S., updating provisions that the Department of Financial Services, not Department of Law Enforcement, is to implement the Stop Inmate Fraud Program;
- Amends 440.385, F.S., correcting reference that the Department of Financial Services, not the Department of Labor and Employment Security, shall approve the Plan of Operation for the Florida Self-Insurers Guaranty Association, Inc.

The bill repeals other provisions which are outdated, no longer effective, applicable, or being implemented.

SB 1676 – Sovereign Immunity: Ch. 11-219, LOF; effective June 24, 2011, and applies to claims accruing on or after that date; by Judiciary Committee and Senators Thrasher and Oelrich.

The bill establishes legislative findings that nonprofit independent private colleges and universities located and chartered in Florida, which own or operate medical schools, and which permit their employees or agents to provide patient services in teaching hospitals pursuant to an affiliation agreement or other contract, should be afforded sovereign immunity protections under s. 768.28, F.S. Additionally, the Legislature declares that there is an overwhelming public necessity for extending the state's sovereign immunity to such entities and that there is no alternative method of meeting such public necessity.

Under the bill, any nonprofit independent college or university located and chartered in Florida, which owns or operates an accredited medical school, or any of its employees or agents, and which has agreed by affiliation agreement or other contract to provide, or to permit its employees or agents to provide, patient services as agents of a teaching hospital, is considered an agent of the teaching hospital while acting within the scope of and pursuant to guidelines established in the contract.

The contract must provide for the indemnification of the teaching hospital, up to certain limits, by the agent for any liability incurred which was caused by the negligence of the college or university or its employees or agents. The contract must also provide that those limited portions of the college, university, or medical school which are directly providing services pursuant to the contract and which are considered an agent of the teaching hospital, are deemed to be acting on behalf of a public agency for purposes of public records laws.

Notice must be provided to each patient, or the patient's legal representative, that the exclusive remedy for injury or damage suffered as the result of any act or omission of the teaching hospital, the college or university, or the employees or agents of the college or university, while acting within the scope of duties pursuant to the contract with the teaching hospital, is by commencement of an action under the state's limited waiver of

sovereign immunity pursuant to s. 768.28, F.S. This notice requirement may be met by posting the notice in a place conspicuous to all persons.

The bill does not designate any employee providing contracted patient services in a teaching hospital as an employee or agent of the state for purposes of workers' compensation insurance.

~~**SB 1738 – State Financial Information**: Ch. 11-___, LOF; effective July 1, 2011; by Governmental Oversight & Accountability Committee and Sen. Alexander.~~ – ***VETOED by Governor 5/26/11***

~~The bill provides for the following:~~

- ~~Creates the Agency for Enterprise Business Services, which is administratively housed in the Department of Management Services, with the Governor and Cabinet as the agency head.~~
- ~~Establishes an executive director, appointed by the Governor and the Cabinet with at least three affirmative votes, who must be confirmed by the Senate.~~
- ~~Provides duties to the new agency including:~~
  - ~~Developing the Enterprise Financial Business Services Strategic Plan;~~
  - ~~Providing assistance to the Chief Financial Officer in developing recommendations for the uniform chart of accounts;~~
  - ~~Serving as a clearinghouse for enterprise information relating to the planning, development, implementation, and evaluation of improvements to enterprise financial business services;~~
  - ~~Making recommendations to the Legislature for additional substantive changes required to implement the Enterprise Financial Business Services Strategic Plan including the associated governance structure.~~

SB 1816 – Surplus Lines Insurance: Ch. 11-46, LOF; effective May 26, 2011; by Banking & Insurance Committee, Budget Subcommittee on Finance & Tax, Budget Committee and Senators Fasano and Richter.

Surplus lines insurance is an alternative type of insurance coverage by which consumers can buy property-liability insurance from unauthorized (non-admitted) insurers when they are unable to purchase needed coverage from admitted insurers. The premiums charged for surplus line coverages are subject to a 5 percent tax on premiums and a service fee of up to 0.3 percent. The Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) was included within the Federal Dodd-Frank Wall Street Reform and Consumer Protection Act. The NRAA (ss. 15 USC-8201- 8206) limits regulatory authority over nonadmitted (surplus lines insurance to the home state of the insured). Under the NRRA, Florida will no longer have jurisdiction to collect taxes and fees on surplus lines policies that cover risks over Florida and other states unless Florida is the home state of the insured, potentially resulting in significant loss of tax revenue. However, the NRRA authorizes states to enter into agreements with one another for home states to collect

taxes on multi-state risks and then allocate tax revenue to the state where the insured risks are located.

The bill applies the surplus lines tax to the entire premium of a surplus lines policy covering risks over multiple states when Florida is the home state of the insured as defined in the NRAA. The bill also authorizes the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR) to enter into cooperative reciprocal agreements with other states to collect and allocate nonadmitted surplus lines insurance taxes for multi-state risks pursuant to the NRRA. The bill authorizes the creation of a clearinghouse to receive the surplus lines premium tax collected by the home state of the insured and disburse the appropriate tax amount to the states where the risks are located. The clearinghouse is also authorized to collect a service fee of 0.3 percent of the gross premium. The tax rate collected on a multi-state surplus lines policy is limited to the tax rate where the insured risk is located. The Legislature is authorized to review any such agreement and may instruct the Chief Financial Officer to withdraw from an agreement if it determines that the agreement is not in the best interest of the state. The DFS must issue a report to the President of the Senate and Speaker of the House of Representatives about the terms and conditions of the agreement.

The bill also creates requirements governing the reporting and payment of surplus lines premium tax revenue and fees for policies covering multi-state risks. Surplus lines agents and insureds that do not use a surplus lines agent to procure coverage, have 45 days after the end of the calendar quarter to file and affidavit describing transactions handled during the last quarter and pay the required premium tax and fees.

SB 2096 – State Financial Information: Ch. 11-49, LOF; effective May 26, 2011; by Budget Committee.

The bill provides for the following:

- Requires charter schools and charter technical career centers to post their financial information on the Transparency Florida website.
- Requires the Auditor General to annually submit to the Legislature and the Department of Financial Services a list of any school districts, charter schools, charter technical career centers, colleges, state universities, and water management districts that have failed to comply with the transparency requirements.
- Changes the exemption criteria for municipalities or special districts from a population threshold (fewer than 10,000) to a revenue threshold (less than $10 million in total annual revenues).
- Requires water management districts to post their financial statements on their websites by September 1, 2011.
- Requires the Chief Financial Officer to make a state contract management system publically available that includes information and documentation relating to contracts procured by state governmental entities.

- Requires agency procurement staff to update information within 30 days of any major change to a contract or the execution of a new contract. A major change includes a contract renewal, extension, termination, or amendment.

SB 2098 – Consolidation/State Information Technology Services: Ch. 11-50, LOF; effective July 1, 2011; by Budget Committee.

The bill provides for the following:

- Clarifies the required components of the Agency for Enterprise Information Technology's annual work plan.
- Clarifies the duties of the Agency for Enterprise Information Technology pertaining to the state data center system, to include developing rules relating to its operation.
- Establishes in statute the agency schedule for data center consolidations, providing requirements for the development and submission of appropriate transition plans, providing requirements for the execution of new or updated service level agreements, and establishing agency limitations pertaining to their agency data centers and email services.
- Provides that approval to transition to a statewide email system is contingent on approval by the Legislative Budget Commission.
- Eliminates the Agency Chief Information Officers Council.
- Eliminates the requirement that agencies hire a Chief Information Officer.

SB 2100 – Retirement: Ch. 11-68, LOF; effective July 1, 2011, except as otherwise provided; by Budget Committee.

The Conference Committee Amendment for SB 2100, 2nd Eng., relating to retirement, provides for the following:

- Effective July 1, 2011, requires 3% employee contribution for all FRS members. DROP participants are not required to pay employee contributions.
- For employees initially enrolled on or after July 1, 2011, the definition of "average final compensation" means the average of the 8 highest fiscal years of compensation for creditable service prior to retirement, for purposes of calculation of retirement benefits. For employees initially enrolled prior to July 1, 2011, the definition of "average final compensation" continues to be the average of the 5 highest fiscal years of compensation.
- For employees initially enrolled in the pension plan on or after July 1, 2011, such members will vest in 100% of employer contributions upon completion of 8 years of creditable service. For existing employees, vesting will remain at 6 years of creditable service.
- For employees, initially enrolled on or after July 1, 2011, increases the normal retirement age and years of service requirements, as follows:
    - For Special Risk Class: Increases the age from 55 to 60 years of age; and increases the years of creditable service from 25 to 30.

- For all other classes: Increases the age from 62 to 65 years of age; and increases the years of creditable service from 30 to 33 years.

- Maintains DROP; however, employees entering DROP on or after July 1, 2011 will earn interest at a reduced accrual rate of 1.3%. For employees currently in DROP or entering before July 1, 2011, the interest rate remains 6.5%.
- Eliminates the cost-of-living adjustment (COLA) for service earned on or after July 1, 2011. Subject to the availability of funding and the Legislature enacting sufficient employer contributions specifically for the purpose of funding the reinstatement of the COLA, the new COLA formula will expire effective June 30, 2016, and the current 3% cost-of-living adjustment will be reinstated.
- To implement the bill for the 2011-12 fiscal year, funds the Division of Retirement with four positions and $207,070 in recurring funds and 31,184 in non-recurring funds.

~~**SB 2106 – FL Energy and Climate Commission**: Ch. 11-___, LOF; effective July 1, 2011; by Budget Committee.~~ – ***VETOED by Governor 5/26/11***

~~The Conference Committee Amendment for SB 2106, relating to the Florida Energy and Climate Commission, provides for the following:~~

- ~~Provides for a type two transfer of the Florida Energy and Climate Commission within the Governor's Office to the Department of Agriculture and Consumer Services;~~
- ~~Abolishes the Commission and transfers the majority of the Commission's duties to the Department of Agriculture and Consumer Services; therefore, CFO's appointment to the Commission is eliminated;~~
- ~~Transfers the duties of petroleum allocation from the Commission to the Division of Emergency Management;~~
- ~~Transfers energy emergency contingency plans to the Division of Emergency Management;~~
- ~~Requires the Department of Management Services to coordinate the energy conservation programs of all state agencies; and~~
- ~~Transfers administration of the Coastal Energy Impact Program to the Department of Environmental Protection.~~

SB 2132 – Department of Financial Services: Ch. 11-59, LOF; effective July 1, 2011; by Budget Committee.

SB 2132, relating to the Department of Financial Services, provides for the following:

- Requires that the Department of Financial Services (department) and all state agencies with more than 3,000 full-time employees that are provided insurance coverage from the Division of Risk Management, within the department, establish and maintain return-to-work programs for injured state workers. This provision is anticipated to result in an estimated annual cost savings of $1 million to the Division of Risk Management's self-insurance program.

- Requires the Division of Risk Management to utilize agency loss prevention results in addition to claims history as criteria for calculating state agency risk management premiums.
- Requires the Division of Risk Management to evaluate each agency's risk management programs at least once every five years and to produce reports recommending improvements. In addition, the bill outlines a process for each agency's response to the division's evaluation and recommendations.
- Eliminates the Chief Financial Officer's authority to operate a check cashing service at the state capitol, which will eliminate three full-time positions and provide a savings of $129,022.
- Requires that unencumbered and undisbursed funds that are transferred from the Workers' Compensation Administration Trust Fund within the department revert back to the fund each year.
- Revises the responsibilities of the Division of Consumer Services within the department to reflect organizational changes related to the Office of Insurance Regulation and the Office of Financial Regulation.
- Authorizes the department to accept donations, grants of property or moneys from any governmental unit, public agency, institution, person, firm, or corporation for its anti-fraud efforts in the Division of Insurance Fraud within the department. The bill authorizes the department to request annual appropriations from these funds.
- Provides for the vesting of certain rights in the Division of Insurance Fraud upon donation.
- Requires that all donations or grants of monies to the Division of Insurance Fraud be deposited immediately into the Insurance Regulatory Trust Fund within the department, to be separately accounted for. The bill authorizes the use of these funds by the Division of Insurance Fraud to carry out its duties and responsibilities or for the sub-granting of funds to the state attorneys for funding or defraying the cost of dedicated fraud prosecutors.

SB 2156 – Government Reorganization: Ch. 11-142, LOF; effective July 1, 2011; by Budget Committee.

REORGANIZATION

- Creates the Department of Economic Opportunity (DEO):
  - Agency head, known as the "executive director," appointed by the Governor and confirmed by the Senate.
  - Transfers the Office of Tourism, Trade and Economic Development (OTTED), portions of the Department of Community Affairs (DCA), and portions of the Agency for Workforce Innovation (AWI) workforce functions to the new agency, effective October 1, 2011.
  - The Ready to Work program is transferred from the Department of Education (DOE) to the Department of Economic Opportunity.

- Transfers the AWI Office of Early Learning to the Department of Education as a separate entity:
  - Director of the office appointed by the Governor, and confirmed by the Senate.
  - DOE may not impose requirements or standards on early learning programs beyond those authorized in law for voluntary prekindergarten (VPK).
  - Auditor General to review programs and delivery systems (including early learning coalitions) by December 31, 2011.

- Consolidates public-private economic development partnerships:
  - Enterprise Florida, Inc., (EFI) President, known as the "Secretary of Commerce," is appointed by and serves at the pleasure of the Governor.
  - EFI board remains largely as it is under current law, however new language requires certain private-sector representation (e.g., space, tourism, etc).
  - Space Florida retains special district status under the direction of appointed EFI board members.
  - VISIT Florida direct support organization is retained under contract with the EFI Board.
  - Black Business Investment Board (BBIB) and Florida Sports Foundation are merged into EFI, and related divisions are created in EFI.
  - Matching requirements for EFI and VISIT Florida (1-to-1 match) remain as required under current law.
  - Workforce Florida, Inc., maintains independent status as currently provided in law.

- Other transfers:
  - Florida Communities Trust and Stan Mayfield Working Waterfronts are transferred from DCA to the Department of Environmental Protection.
  - Florida Building Commission is transferred from DCA to the Department of Business and Professional Regulation.
  - Division of Emergency Management is transferred from DCA to the Executive Office of the Governor.
  - Florida Energy and Climate Commission within the Executive Office of the Governor is transferred to the Department of Agriculture and Consumer Services.

- Repeals DCA, AWI, and OTTED.
- Repeals 216.235 – Innovation Investment Program. With the repeal of the program, the State Innovation Committee is repealed. CFO is a member.
- Repeals 287.115 – Requires the CFO– submit an annual report to the Auditor General on contractual service contracts disallowed by the CFO.

PURPOSE AND FUNCTIONS OF THE DEPARTMENT OF ECONOMIC OPPORTUNITY

- Responsibilities of the department:

- Oversight and coordination of economic development, housing, growth management, community development programs, and unemployment compensation.
- Develop a single, statewide 5-year strategic plan to address the promotion of business formation, expansion, recruitment, and retention in order to create jobs for all regions of the state. The plan must address economic development, marketing and infrastructure development for rural communities.
- Submit an annual report on the condition of the business climate and economic development in the state, with assistance from EFI and WFI.
- Manage the activities of the public-private partnerships.
- Establish annual performance standards for Enterprise Florida, Inc., Workforce Florida, Inc., VISIT Florida, and Space Florida and report annually on how these performance measures are being met.

➢ Streamlined incentive process:
  - Incentives for economic development projects must be approved or denied within 10 days of submitting an application to the department.
  - The release of funds for the incentive or incentives awarded to the applicant depends upon the statutory requirements of the particular incentive program.
  - Quick Action Closing Fund projects require recommendation to the Governor in 7 days. In addition, the Governor can approve projects under $2 million. Projects ranging from $2 million - $5 million require notification to the chairs and vice chairs of the Legislative Budget Commission (LBC). Projects totaling more than $5 million must be approved by the LBC.

➢ Business plan required by September 1, 2011, in conjunction with EFI, must outline:
  - Strategies to be used by department and EFI for business recruitment and expansion.
  - Benchmarks related to: business recruitment, business expansion, number of jobs created or retained.
  - Tools, financial and otherwise, needed to achieve benchmarks, and timeframes necessary to achieve standards.
  - By Jan. 1, 2012, the department must make recommendations for any further reorganization and streamlining of economic development and workforce functions.

<u>PURPOSE AND FUNCTIONS OF ENTERPRISE FLORIDA, INC.</u>

➢ Responsibilities of EFI:
  - Must enter a performance-based contract with the Department of Economic Opportunity.
  - Acts as primary economic agency for the state; chief negotiator for business recruitment and business expansion.
  - Increase private investment in Florida.

- Advance international and domestic trade opportunities.
- Market the state as a pro-business location for new investment and as a tourist destination.
- Revitalize Florida's space and aerospace industries.
- Promote opportunities for minority-owned businesses.
- Assist and market professional and amateur sports teams and sporting events.
- Assist and promote economic opportunities in rural and urban communities.

➢ Annual incentive report must include:
  - Description of incentive programs.
  - Amount of awards granted, by year, since inception.
  - Economic benefits including actual amount of private capital invested, actual number of jobs created, actual wages paid for incentive agreements, annual average wage.
  - The number of applications submitted, and the number of projects approved and denied by the department.
  - Federal and local incentives provided.
  - The number of projects that did not fulfill the terms of their agreements and consequently did not receive incentives.
  - Trends related to usage of the various incentives, including the number of minority-owned businesses receiving incentives.

<u>DEEPWATER HORIZON OIL SPILL</u>

➢ To address the negative economic impacts of the Deepwater Horizon oil spill:
  - Defines the following counties as "disproportionally affected counties" and waives job, wage, and other requirements for businesses seeking economic development incentives in these counties: Bay, Escambia, Franklin, Gulf, Okaloosa, Santa Rosa, Walton, and Wakulla.
  - Provides that during a state of emergency permits are tolled and an additional 6 months is added to existing permits.
  - Creates the Commission on Oil Spill Response Coordination (expires Sept. 2012).
  - Appropriates $10 million per year for three fiscal years to develop and implement an economic strategic plan in counties designated as disproportionally affected.
  - Directs how funds received by the state for damages caused by the Deepwater Horizon oil spill may be directed.

<u>STATE ECONOMIC ENHANCEMENT AND DEVELOPMENT (SEED) TRUST FUND</u>

(HB 7205 creates the SEED Trust Fund within the Department of Economic Opportunity)

➢ This bill provides:
  - Effective July 1, 2012, redirects a total of $75 million from documentary stamp tax revenues, currently dedicated to affordable housing trust funds, into the SEED Trust Fund.

- Effective July 1, 2012, begins redirecting from documentary stamp tax revenues currently dedicated to the State Transportation Trust Fund (STTF) into the SEED Trust Fund. In order to lessen the impacts to the Florida Department of Transportation (FDOT) Work Program, the bill phases-in the amounts to be redirected as follows: $50 million for Fiscal Year 2012-13; $65 million for Fiscal Year 2013-14; and $75 million for Fiscal Year 2014-15 and subsequent years.
- The above-mentioned funds are to be appropriated annually in the General Appropriations Act.
- The affordable housing trust funds are maintained as in current law.

FLORIDA ENERGY AND CLIMATE COMMISSION PROVISIONS

- Provides for transfer of the powers, duties, and functions of the Florida Energy and Climate Commission within the Governor's Office to the Department of Agriculture and Consumer Services and abolishes the Commission of which the Chief Financial Officer was a member.
- Transfers the duties of petroleum allocation from the Commission to the Division of Emergency Management.
- Transfers energy emergency contingency plans to the Division of Emergency Management.
- Requires the Department of Management Services to coordinate the energy conservation programs of all state agencies.
- Transfers administration of the Coastal Energy Impact Program to the Department of Environmental Protection.

SB 2160 – Dept. of Highway Safety and Motor Vehicles: – Ch. 11-66, LOF; effective July 1, 2011; by Budget Committee.

The bill contains provisions relating to the Department of Highway Safety and Motor Vehicles. One of the provisions provides that the department may contract with a vendor to outsource the online sale of crash records.

With regards to automobile accidents, the bill codifies driver exchange-of-information forms, which are currently used by law enforcement. The bill keeps intact the election of officers to use a short form or exchange-of-information form in situations that do not necessitate the use of a long-form, but it requires that all short forms list the names and addresses of all drivers and passengers. Lastly, the bill removes the requirement that a long-form be used in situations where a vehicle is rendered inoperative to a degree that it must be removed from traffic.

<u>HB 4129 – Residential Property Structural Soundness Evaluation Grant Program</u>: Ch. 11-12, LOF; effective July 1, 2011; by Rep. Crisafulli.

The bill repeals section 627.0629(8), F.S., which establishes a mitigation evaluation grant program for policyholders of Citizens Property Insurance Corporation (Citizens) insured in the high-risk account. Repealing s. 627.0629(8), F.S., will preclude certain policyholders of Citizens from receiving grants from the state to use to pay for a mitigation inspection. However, no funding has been provided by the state since the program's authorization.

<u>HB 4181 – Prohibited Activities of Citizens Property Insurance Corporation</u>: Ch. 11-13, LOF; effective July 1, 2011; by Rep. Davis.

The bill repeals s. 215.55951, F.S., which precludes Citizens from increasing rates or assessments due to the $250 million transfer of funds to the Capital Build-Up Program in 2008 or due to changes to the program contained in CS/CS/SB 2860 which was enacted in 2008 (Ch. 08-66, LOF).

<u>HB 7107 – Medicaid Managed Care</u>: Ch. 11-134, LOF; effective July 1, 2011; by Appropriations Committee, Health & Human Services Committee and Rep. Schenck.

The bill establishes the Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. The Agency for Health Care Administration (AHCA) is directed to apply for and implement amendments to the Medicaid state plan or waivers of applicable federal laws and regulations by August 1, 2011, necessary to implement the program. The AHCA is directed to provide public notice and seek public comment before applying for such waivers and is required to include public feedback in waiver applications.

The new Medicaid program consists of two components:

- **Managed Medical Assistance**
  Provides medically-necessary primary and acute health care services such as doctor's visits, hospitalization, pregnancy care, prescription drugs, etc.

- **Managed Long-Term Care**
  Provides individuals who are aged and/or disabled, and who meet additional acuity levels, with additional services beyond routine health care needs such as adult day care, home delivered meals, personal care, case management, etc.

All Medicaid recipients will be enrolled in managed care plans unless specifically exempt. Recipients who are exempted include persons with limited eligibility or benefits and persons with developmental disabilities.

A variety of managed care plans may participate in the program. A recipient has a choice of plans and plan types that are contracted by the AHCA in the recipient's region of residence. Recipients may choose between insurers, exclusive provider organizations, health maintenance organizations (HMOs), and other managed care plans run by health care providers or groups of providers, such as provider service networks (PSNs) or accountable care organizations (ACOs). Recipients may also choose specialty plans with expertise in specific medical conditions.

Plans will compete for Medicaid contracts via an invitation-to-negotiate process based on specified qualifications, such as price, provider network adequacy, accreditation, community partnerships, additional benefit offerings, and performance history.

- Specific factors are identified for the AHCA to use in selecting bidders to participate in negotiations. Critical factors include:
  - Accreditation and experience
  - Sufficient primary and specialty physicians in the network
  - Community partnerships
  - Commitment to quality improvement
  - Coverage of additional benefits including dental care and disease management
  - Evidence of established relationships with providers
  - Input from providers
  - Documentation of policies to prevent fraud and abuse.

- Plans must reveal their business relationships so that one company cannot dominate a region and prevent Medicaid recipients from having a real choice among plans.

- Preference will be given to plans that demonstrate:
  - Signed contracts with primary and specialty physicians and with essential providers;
  - Well-defined programs for recognizing patient-centered medical homes and accountable care organizations;
  - Ability to produce a greater economic benefit by being headquartered in Florida and employing Floridians to meet contract terms;
  - Provider networks in which over 10 percent of providers use electronic health records;
  - A contract with AHCA to provide managed long-term care services in the same region;
  - Contracts or other arrangements for cancer disease management programs;
  - Contracts or other arrangements for diabetes disease management programs;
  - A process for prompt payment of claims.

There will be a limited number of plans in each of eleven regions to promote plan stability but also provide choices to recipients.

Insurers and HMOs will be prepaid on a full-risk basis via a monthly capitated rate designed to represent the costs needed to provide all medically necessary services in the aggregate during any month-long period. Capitation rates will be risk-adjusted based on patient encounter data. Risk-adjusted rates will ensure plans are paid more for sicker patients in order to allocate resources appropriately.

Provider service networks will have the option of assuming risk immediately or being paid on a fee-for-service basis for the first 2 years of operation, after which a PSN that initially opted to be paid via fee-for-service must convert to a full-risk capitation payment.

During the first year of the first contract term, managed care plans, including prepaid plans and PSNs paid via fee-for-service, must guarantee a savings of at least 5 percent from the amount they would have been paid in the previous year based on service area and population.

Managed care plans will be held accountable:

- Payment to physicians must be equal to or exceed Medicare rates after 2 years of continuous plan operation.
- Prescription drug formularies or preferred drug lists must be accessible on the plan's website.
- Prior authorization requests must be accepted electronically.
- Provider networks must meet specific adequacy standards, and plans must maintain an online database of network providers that can be used by consumers and the AHCA.
- Valid encounter data must be submitted on time.
- Plans must provide quality data measures on their websites to allow recipients to compare plans.
- Plans must be accredited by a nationally recognized accrediting body or seek accreditation by such a body within one year of plan operation.
- Performance must continuously improve based on specific standards that are raised over the term of the contract.
- Active systems must be used to reduce the incidence of fraud and abuse.
- All recipients must have access to a grievance process.
- Financial penalties will be imposed and contracts will be terminated for reducing enrollment or withdrawing prior to the end of a contract term.
- Financial penalties will be imposed on plans that fail to comply with encounter data reporting requirements. If the plan does not comply within 90 days, its contract will be terminated.

Limits will be placed on how much profit can be earned by managed care plans to ensure that plans are not overspending on administration or earning profit at the expense of patient care. This system of "achieved savings rebates" will require plans that exceed an appropriate profit threshold to pay dollars back to the state, thereby eliminating an incentive to withhold appropriate spending on health care services:

- Administrative fees are restricted to actuarially appropriate levels.
- Effective management of care will achieve savings that will be shared with the state.
- Plans may retain a reasonable profit of up to a 5 percent margin. Plans must pay back a portion of profits above that threshold and must pay back all profits above a 10 percent margin.
- Plans can earn an additional one percent profit if they demonstrate exceptional performance.
- Plans will be required to perform and submit detailed audits to verify the achieved savings rebates.

Intergovernmental Transfer Process:
- Local funding sources may contribute funds to the state Medicaid program.
- Specific conditions apply to the local contributions.
- The Low Income Pool is restructured to function within a managed care environment.
- The Access to Care Partnership is created as a single organization representing all providers designated by local funding sources as eligible to receive support through the Low Income Pool.
- Any additional resources generated by the local contributions may be used to enhance hospital payment rates through a specific formula for hospitals classified in three tiers. All hospitals will receive some benefit from tiered rate increases.

Medicaid recipients will have an opportunity to choose among plans in their region. Those who do not choose a plan will be automatically enrolled, with a preference for enrollment in specialty plans if there is one available to serve their particular condition. This will ensure recipients are served by plans with expertise in their specific disease states.

The AHCA is directed to develop a process to enable a recipient with access to employer-sponsored coverage to opt-out of all Medicaid managed care plans and use Medicaid financial assistance to pay the recipient's share of the cost for the employer-sponsored coverage, and the AHCA is directed to seek federal approval to require such recipients to opt-out of Medicaid managed care in favor of their employer-sponsored coverage. The AHCA is also directed to seek federal approval to enable recipients with access to other insurance or related products that provide access to health care services, including products available under the Florida Health Choices program or any health exchange, to opt-out. The amount of financial assistance provided for any such recipient may not exceed the amount the Medicaid program would have paid to a Medicaid managed care plan for that recipient.

Participation in the Medicaid managed care medical assistance component by the Children's Medical Services Network will be under a single, statewide contract with the AHCA that is not subject to the program's procurement process or the regional limitation on the number of plans. However, the Children's Medical Services Network must meet all other plan requirements for the managed medical assistance component.

Managed Medical Assistance

The bill creates the managed medical assistance component for primary and acute care services. Implementation of the medical assistance component begins January 1, 2013, and is scheduled to be fully implemented by October 1, 2014. All mandatory and optional primary and acute care services are covered in the program, and plans can offer additional benefits.

Plans contracted for the medical assistance component must:

- Maintain adequate provider networks
- Monitor quality and performance standards of their providers
- Contract with Healthy Start Coalitions to improve outcomes for pregnant women and infants.
- Ensure at least 80 percent of their enrolled children receive their well-child screening by the end of the second year in pursuit of proper preventive care and treatment.

The bill requires medical assistance plans to contract with certain "essential providers," which include:

- Federally qualified health centers;
- Statutory teaching hospitals;
- Hospitals that are trauma centers;
- Hospitals located at least 25 miles from any other hospital with similar services;
- Faculty plans of Florida medical schools;
- Regional perinatal intensive care centers;
- Specialty children's hospitals;
- Accredited and integrated systems serving medically complex children that comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and prescribed pediatric extended care.

The bill sets reimbursement mandates for plans that are unable to contract with essential providers.

The bill brings the Medically Needy population into managed care under certain conditions that are contingent on federal approval. After being deemed eligible for the Medically Needy program, recipients will be enrolled in managed care plans and pay a portion of the managed care plan premium, based on their income and share of cost as determined by the Department of Children and Families. The state will pay the remaining portion of the premium to the managed care plan.

Managed Long-term Care

The bill creates the managed long-term care component for Medicaid recipients eligible for long- term care services. Implementation of the long-term care component will begin July 1, 2012, and is scheduled to be fully implemented in all regions by October 1, 2013.

The managed long-term care component covers:

- Medicaid recipients who are age 65 or older, or age 18 or older and eligible for Medicaid by reason of a disability; and
- Determined by the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES) program to require nursing facility care.

Medicaid recipients, who, on the date long-term care plans become available in their region, reside in a nursing home facility or are enrolled in certain long-term care Medicaid waiver programs, are eligible to participate in the long-term care component for up to 12 months without being reevaluated for their need for nursing facility care.

There will be two types of long-term care plans:

- Comprehensive long-term care plans that combine medical assistance and long-term care services
- Long-term care plans that provide only long-term care services

Selection preference will be given to comprehensive plans so seniors can receive all services from one plan. Plans will provide residential care in nursing facilities or assisting living facilities. The plans also must offer a comprehensive range of home and community based services for the care of seniors or the disabled who need assistance but not round-the-clock nursing care. Eligible plans must have specialized staffing with experience in serving elders and the disabled.

Long-term care plans must provide a complete range of services throughout their regions and must have needed providers such as nursing homes, assisting living facilities, and hospices in their networks.

A long-term care plan's network must include all of the following:

- Adult Day Center Centers
- Adult Family Care Homes
- Assisted Living Facilities
- Health Care Services Pools
- Home Health Agencies
- Homemaker and Companion Services
- Hospices
- Lead Agencies
- Nurse Registries
- Nursing Homes

Long-term care recipients who are referred to nursing homes or assisted living facilities will be informed of facilities within the plans that are associated with specific religious or cultural affiliations, and a reasonable effort must be made to place the recipient in the facility of their choice.

The bill provides an additional choice for hospice patients. When a senior is referred for hospice services, the senior will have a 30-day period in which to change plans if a preferred hospice provider is only available through another plan.

When a recipient does not choose a long-term care plan, auto-assignment will be based on the quality measures of plans in the region. Members of certain Medicare Advantage plans who are also Medicaid-eligible and who do not choose a Medicaid plan will be assigned to their Medicare Advantage plan for applicable Medicaid services if their Medicare Advantage plan has contracted with the AHCA for the Medicaid long-term care component.

Medicare Advantage plans that serve only individuals who are dually eligible (qualify for both Medicare and Medicaid) may enter into a contract with the AHCA and will not be subject to the procurement requirements contained in the bill. All other Medicare plans will be subject to competitive procurement.

Program for All Inclusive Care for the Elderly (PACE) plans are eligible plans and are not subject to the procurement process or region limits. They may continue to serve recipients at the enrollment caps set by the Legislature.

The bill focuses on keeping seniors in their homes as long as possible. Home and community based care is both required and rewarded. Payment rates for long-term care plans will be adjusted to create incentives for keeping individuals out of nursing homes when in-home accommodations and care can be arranged instead of nursing home care.

Long-term care plans are required to pay nursing homes and hospices at payment levels established by the AHCA.

HB 7109 – Medicaid: Ch. 11-135, LOF; effective July 1, 2011, by Health & Human Services Committee, Appropriations Committee and Rep. Schenck.

The bill is designed to conform certain provisions of existing Medicaid law to CS/HB 7107, 3rd Engrossed, and authorizes a number of immediate changes to the Medicaid program. The bill also repeals numerous provisions on future dates to conform general Medicaid provisions to the full implementation of the Medicaid managed care program. The bill becomes effective only if CS/HB 7107, 3rd Engrossed, is enacted.

Persons with Developmental Disabilities

- The bill expands eligibility for the home and community-based waiver program for persons with developmental disabilities to include individuals diagnosed with Down Syndrome.
- If the Agency for Persons with Disabilities continues a deficit during fiscal year 2012-2013, the agency must submit a plan to the Legislature for a redesigned waiver program as an alternative to current waiver models. The new program model must include specific elements (e.g., budget predictability and redesigned

support coordination services) and be approved by the Legislature before implementation on July 1, 2014.

Medicaid Program

- The bill expands the disqualification for receiving Medicaid benefits from 5 to 10 years for a person found to have committed Medicaid fraud.
- The Agency for Health Care Administration (AHCA) is directed to request federal approval to develop a system to require parents with household incomes greater than 100 percent of the federal poverty level to pay premiums or other cost sharing methods for home and community-based services for their developmentally disabled children.
- The AHCA is directed to request federal approval to require Medicaid recipients to pay $100 co-payments for nonemergency services provided in a hospital emergency department.
- The bill provides that Medicaid shall not pay for psychotropic medications for a child unless specifically authorized by the parent or guardian.
- The AHCA is directed to develop a process to enable a recipient with access to employer-sponsored coverage to opt-out of all Medicaid managed care plans and use Medicaid financial assistance to pay the recipient's share of the cost for the employer-sponsored coverage. The AHCA is also directed to seek federal approval to enable recipients with access to other insurance or related products that provide access to health care services, including products available under the Florida Health Choices program or any health exchange, to opt-out. The amount of financial assistance provided for any such recipient may not exceed the amount the Medicaid program would have paid to a Medicaid managed care plan for that recipient.

Medicaid Managed Care

- The AHCA is required to develop uniform accounting and reporting requirements for Medicaid managed care plans. The plans must begin reporting their medical and non-medical costs to the AHCA. This information must be made public will help ensure that plans are providing adequately managed, patient-centered care.
- Plans will be given advance notice and an opportunity to comment on any potential rate adjustments. The AHCA will perform a simulated rate-setting exercise prior to making rate adjustments, the results of which must be posted on the AHCA's website for 45 days.
- The current option for Medicaid recipients in one of the five Medicaid Reform pilot counties to use their Medicaid premium to purchase employer-sponsored insurance is permitted statewide. This option is further expanded (subject to federal approval) by allowing recipients to use their Medicaid dollars to pay for other insurance or products that may be available to them.
- The AHCA is authorized to exempt recipients from managed care on a case-by-case basis for specialized or unique, time-limited, and ongoing care that patients may be receiving at the time they enroll in Medicaid.

- The AHCA is required to contract with prepaid dental plans until Medicaid managed care is fully implemented in all regions under CS/HB 7107, 3rd Engrossed.

Hospital Rates

- The AHCA is directed to implement a methodology for establishing Medicaid reimbursement rates for each hospital based on allowable costs. The rates will be set once annually and the reconciliation period is limited. This process is designed to provide budgetary certainty and administrative simplification.
- The AHCA is directed to develop a plan to convert inpatient hospital rates to a prospective payment system that uses diagnosis related groups (DRG) and assigns a payment weight.
- The AHCA must submit the Medicaid DGR plan to the Governor and Legislature by January 1, 2013.

Provider Service Networks

- The same payment requirements applicable to provider service networks (PSNs) in the five Medicaid Reform pilot counties are applied to all PSNs statewide in order to prepare them for expansion of managed care under CS/HB 7107, 3rd Engrossed.
- PSNs may still be fee-for-service for a period of time, but specific requirements are established for shared savings and guidelines are defined for a reconciliation process that determines shared savings.
- A prepaid PSN that applies for and obtains a health care provider certificate from the AHCA, meets the surplus requirements for health maintenance organizations (HMOs) under the Insurance Code, and meets all other applicable requirements relating to the regulation of health maintenance organizations (HMOs), may obtain a certificate of authority under the Insurance Code relating to HMOs. A certified PSN is granted the same rights and responsibilities as a certified HMO. The bill creates an exception in the Insurance Code's solvency requirements for PSNs to specify that a PSN seeking a certificate of authority must meet the bill's surplus requirements instead of those under existing law.

MediPass

AHCA is directed to contract with a single PSN to function as a third party administrator and managing entity for the MediPass program in all counties with fewer than two prepaid plans. The contract will expire when the managed care program is fully implemented under the provisions of CS/HB 7107, 3rd Engrossed.

Medically Needy Program

- The AHCA is directed to immediately contract with a PSN to coordinate and manage the care of the Medically Needy. Such recipients will be continuously enrolled for a period of 6 months. The enrollees will pay their share of costs as a monthly premium and enrollees will be given a 90 day grace period for late payments of their share of costs.

- The Medically Needy contract with the PSN will expire when the managed medical assistance program is effective statewide under CS/SB 7107, 3rd Engrossed.
- Additionally the AHCA is directed to develop a plan for transitioning Medically Needy recipients into the managed medical assistance program. The AHCA is to immediately seek any federal authorization needed for the implementation.

Tort Reform

- To encourage greater participation by medical practitioners in the Medicaid program, the bill creates limitations on noneconomic damages for negligence of a practitioner providing services and care to a Medicaid recipient.
- Noneconomic damages may not exceed $300, 000 per claimant unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner, defined as acting in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.
- An individual practitioner is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless a claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner.
- For the bill's limitations on noneconomic damages, the term "practitioner," in addition to practitioners included in the definition under s. 766.118(1), F.S., includes hospitals, ambulatory surgical centers, and mobile surgical facilities.

The Department of Elder Affairs

- The Department of Elder Affairs (DOEA), which currently manages waivers related to elder care, will no longer manage the waiver programs once managed care is implemented statewide under CS/HB 7107, 3rd Engrossed. However, the DOEA will still play key roles in transitioning their clients to managed care plans as the plans are available in each region.
- This bill recognizes that continued support of the DOEA is important to the Medicaid program and will still play a role in assessing or assisting recipients. CARES staff at the DOEA will continue to assist with initial assessments of an enrollee's level of care and will be responsible for assisting clients to interact with plans.
- Aging Resource Centers (ARCs) will provide enrollment and coverage information about the Medicaid managed care long-term care program under CS/HB 7107, 3rd Engrossed.
- ARCs can assist elders with information about services and long-term care managed care; help recipients resolve complaints; and make initial assessments about elders' needs.

Nursing Home Certificate of Need

- The bill extends the moratorium on certificates of need (CONs) for additional nursing home beds until the Medicaid managed care program under CS/HB 7107, 3rd Engrossed, is implemented statewide or October 1, 2016, whichever is earlier.
- Effective July 1, 2012, the bill prohibits the AHCA from imposing a sanction on a nursing home for failure to meet the Medicaid patient-day utilization conditions for that nursing home.

AHCA Reorganization

- The AHCA is directed to develop a reorganization plan for realignment of administrative resources of the Medicaid program to respond to changes in functional responsibilities and priorities necessary for implementation of CS/HB 7107, 3rd Engrossed.
- The reorganization plan must assess the AHCA's current capabilities, identify shifts in staffing and other resources necessary to strengthen procurement and contract monitoring functions, and establish an implementation timeline.
- The plan must be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate by August 1, 2011.

HB 7155 – State Board of Administration Investments: Ch. 11-100, LOF; effective July 1, 2011; by Government Operations Subcommittee and Rep. Patronis.

The bill authorizes the State Board of Administration (SBA) to invest the assets of participating government entities in the Local Government Surplus Funds Trust Fund after the entity completes Local Government Investment Pool (LGIP) enrollment materials. A separate trust agreement is no longer needed by the SBA to manage and invest funds in the LGIP.

In addition, the bill provides that the investments that are made by trust agreement between the SBA and a government entity are not subject to the limitations contained in s. 215.44, F.S. The only restrictions or limitations that the investments are subject to are the restrictions and limitations contained in the trust agreement entered into between the government entity and the SBA.

The bill clarifies that officers and employees involved in the investment process must refrain from personal transactions with the individual employee at the broker-dealer firm involved in business conducted with the SBA. It also clarifies the conflict of interest provision applicable to the investment advisor and manager.

HB 7223 – OGSR/Competitive Solicitations: Ch. 11-140, LOF; effective June 2, 2011; by State Affairs Committee, Government Operations Subcommittee and Rep. Patronis.

Public Record Exemptions under Review
The bill reenacts, expands, and reorganizes the public record exemption for competitive solicitations.

First, the bill removes reference to invitation to bid (ITB), request for proposal (RFP), and invitation to negotiate (ITN), by creating a definition for competitive solicitation. It is defined to mean "the process of requesting and receiving sealed bids, proposals, or replies in accordance with the terms of a competitive process, regardless of the method of procurement." By creating a definition of competitive solicitation and removing references to chapter 287, F.S., local governments are able to use the public record exemption associated with ITNs.

Current law protects sealed bids or proposals until a decision or intended decision is made or within 10 days after bid or proposal opening. In addition, sealed replies are protected until a decision or intended decision is made or until 20 days after the final competitive sealed reply is opened. Based upon discussions with impacted parties, the bill creates consistency by providing that all sealed bids, proposals, or replies are exempt until notice of an intended decision or until 30 days after opening the bids, proposals, or final replies. Also, the bill provides that all bids, proposals, or replies may not remain exempt for longer than 12 months after the initial agency notice rejecting all bids, proposals, or replies. Current law only applies to responses to an ITN.

Because the bill expands the current public record exemptions, it extends the repeal date for the exemptions from October 2, 2011, to October 2, 2016. It also provides a public necessity statement as required by the State Constitution.

Public Meeting Exemption under Review
The bill reenacts, expands, and reorganizes the public meeting exemption for competitive solicitations.

The bill creates a definition for "competitive solicitation" identical to the one provided for the public record exemption. Creating a definition of competitive solicitation and removing references to chapter 287, F.S., allows local governments to use the public meeting exemption associated with ITNs.

The public meeting exemption is expanded to include any portion of a meeting at which a vendor makes an oral presentation or a vendor answers questions as part of a competitive solicitation. It is further expanded to include any portion of a team meeting at which negotiation strategies are discussed.

The bill expands the public record exemption for recordings of exempt meetings to comport with the public record exemption for sealed bids, proposals, or replies. It extends

the public record exemption from 20 days to 30 days. It also expands the public record exemption by including those records presented by a vendor at a closed meeting.

Because the bill expands the current exemptions, it extends the repeal date for those exemptions from October 2, 2011, to October 2, 2016. It also provides a public necessity statement as required by the State Constitution.

HB 7225 – OGSR/SBA Alternative Investments: Ch. 11-101, LOF; effective October 1, 2011; by Government Operations Subcommittee and Representatives Patrtonis and Williams.

The bill removes the repeal date, thereby reenacting the public record exemption for proprietary confidential business information held by the SBA regarding alternative investments. The bill revises the definition of what does not constitute proprietary confidential business information to include:

> A description of any compensation, fees, or expenses, including the amount or value, paid or agreed to be paid by a proprietor to any person to solicit the board to make an alternative investment through an alternative investment vehicle. This does not apply to an executive officer, general partner, managing member, or other employee of the proprietor, who is paid by the proprietor to solicit the SBA to make such investments.

In addition, the bill requires the SBA to maintain a list and a description of the records covered by any verified, written declaration made by a proprietor.

Finally, the bill transfers the public record exemptions for the SBA from s. 215.44(8), F.S., to a newly created s. 215.440, F.S.

SB 2000—Relating to Appropriations

This year's Appropriations Bill contains a host of provisions relating to the Department of Financial Services. Major Issues from the final Appropriations Bill are reflected below; because these are not comprehensive, we encourage you to consult the Budget Office with additional questions.

		CONFERENCE				
		FTE	GR TOTAL	TF TOTAL	TOTAL ALL FUNDS	
1	**MAJOR REDUCTION ISSUES**					1
2	ELIMINATE CHECK CASHING SERVICE AT CAPITOL	(3.00)	-	(129,022)	(129,022)	2
3	REDUCTION IN PUBLIC ASSISTANCE FRAUD	-	45,466	(621,950)	(576,484)	3
4	REDUCTIONS DUE TO SPAN OF CONTROL	(25.00)	-	(1,561,924)	(1,561,924)	4
5	REDUCE VACANT POSITIONS AND POSITIONS OVER 180 DAYS	(35.50)	-	(1,950,517)	(1,950,517)	5
6						6
7	**MAJOR FUND SHIFTS**					7
8	FUND SHIFT PAF FROM GENERAL REVENUE TO INSURANCE REGULATION TF - DEDUCT		(1,863,641)	-	(1,863,641)	8
9	FUND SHIFT PAF FROM GENERAL REVENUE TO INSURANCE REGULATION TF - ADD		0	1,863,641	1,863,641	9
10						10
11	**MAJOR NEW ISSUES**					11
12	STATE AND LOCAL CHART OF ACCOUNTS - STATE FINANCIAL INFORMATION AND ACCTG	3.00	300,000	0	300,000	12
13	TRANSPARENCY					13
14	REQUIRED FLAIR MODIFICATION DUE TO IRS CODE 3402 (\$750,000 GR NR)	11.00	1,250,000	394,541	1,644,541	14
15	RETIREMENT BILL APPROPRIATION (CY NR approp)			250,000	250,000	15
16	JAC ATTORNEYS (direct approp. to JAC 1 Miami, 2 Hillsborough; each group = para & prosecutor for a total of 6 FTE)		450,000		450,000	16
17						17
18	**TRUST FUND SWEEP**					18
19	Insurance Regulatory		0	8,500,000	8,500,000	19
20						20
21	**BUDGET ENTITY REDUCTION DETAIL**					21
22	Executive Direction & Support Services	(10.00)	-	(791,679)	(791,679)	22
23	Legal Services	(0.50)	-	(17,815)	(17,815)	23
24	Information Technology	(11.00)	-	(778,374)	(778,374)	24
25	Consumer Advocate	(4.00)	-	(439,589)	(439,589)	25
26	IT - FLAIR	-	(346,446)	-	(346,446)	26
27	Treasury	(3.00)	-	(129,022)	(129,022)	27
28	Accounting and Auditing	-	-	(1,513,285)	(1,513,285)	28
29	Unclaimed Property	(3.00)	-	(168,865)	(168,865)	29
30	Fire Marshal - Compliance & Enforcement	(1.50)	-	(53,576)	(53,576)	30
31	Fire Marshal - Fire & Arson	(1.00)	-	(79,021)	(79,021)	31
32	Fire Marshal - Professional Training	(1.00)	-	(257,905)	(257,905)	32
33	Fire Marshal - Administrative	(3.00)	-	(306,808)	(306,808)	33
34	Risk Management	(2.00)	-	(111,444)	(111,444)	34
35	Rehabilitation & Liquidation	-	-	(36,755)	(36,755)	35
36	Agency & Agency Services	(13.00)	-	(678,153)	(678,153)	36
37	Insurance Fraud	(7.00)	-	(479,809)	(479,809)	37
38	Consumer Assistance	(7.00)	-	(745,517)	(745,517)	38
39	Funeral & Cemetary	-	-	-	-	39
40	Public Assistance Fraud			(621,950)	(1,076,484)	40
41	Workers' Compensation	(26.00)	-	(1,885,168)	(1,885,168)	41
42	Various	-	(3,276)	(98,749)	(102,025)	42
43	**TOTAL REDUCTIONS**	**(93.00)**	**(349,722)**	**(9,193,564)**	**(9,997,820)**	43