Appropriations Committee

Tuesday, February 18, 2020
11:30 AM – 2:30 PM
Webster Hall (212 Knott Building)

Committee Meeting Packet

Jose Oliva
Speaker

W. Travis Cummings
Chair

The Florida House of Representatives

Appropriations Committee

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AGENDA

Tuesday, February 18, 2020
212 Knott Building (Webster Hall)
11:30 AM – 2:300 PM

I. Call to Order/Roll Call

II. Opening Remarks by Chair Cummings

III. Consideration of the following bills:

CS/HB 579 Public Financing of Construction Projects by Agriculture & Natural Resources Subcommittee, Aloupis

CS/HB 605 Senior Management Service Class by Oversight, Transparency & Public Management Subcommittee, Pritchett, Plakon

CS/HB 731 Agency for Health Care Administration by Health Market Reform Subcommittee, Perez

CS/HB 895 Insurance by Insurance & Banking Subcommittee, Santiago

HB 1387 Sale of Surplus State-owned Lands by Grant, J.

HB 6507 Relief/Clifford Williams/State of Florida by Daniels

HB 7059 Jurisdiction of Appellate Courts by Judiciary Committee, Fernandez-Barquin

HB 7077 Postsentencing Forensic Analysis by Criminal Justice Subcommittee, Grant, J.

IV. Closing Remarks and Adjournment

221 The Capitol, 402 South Monroe Street, Tallahassee, FL 32399-1300
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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 579 Public Financing of Construction Projects
SPONSOR(S): Agriculture & Natural Resources Subcommittee, Aloupis
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 178

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Agriculture & Natural Resources Subcommittee	11 Y, 0 N, As CS	Melkun	Moore
2) Appropriations Committee		White CCW	Pridgeon
3) State Affairs Committee			

SUMMARY ANALYSIS

With 1,350 miles of coastline and relatively low elevations, Florida is particularly vulnerable to coastal flooding. One of the primary ways that climate change influences coastal flooding is through sea-level rise. Sea-level rise is an observed increase in the average local sea level or global sea level trend. Florida's coastal communities are experiencing high-tide flooding events with increasing frequency because sea-level rise increases the height of high tides. In the U.S., sea-level rise and flooding threaten an estimated $1 trillion in coastal real estate value, and analysts estimate that Florida could lose more than $300 billion in property value by 2100.

Under current law, coastal construction is regulated by the Department of Environmental Protection (DEP) in order to protect beaches and dunes from construction that can jeopardize the stability of the beach-dune system, accelerate erosion, provide inadequate protection to upland structures, endanger adjacent properties, or interfere with public beach access.

The bill prohibits a governmental entity from commencing construction of a state-funded coastal structure unless the entity has conducted a sea level impact projection (SLIP) study, submitted the SLIP study to DEP, and received notification from DEP that the SLIP study was received and has been published on DEP's website.

The bill requires DEP to adopt a standard by rule for conducting the SLIP study and specifies that the standard must require the governmental entity to:

- Use a systematic, interdisciplinary, and scientifically accepted approach in conducting the SLIP study;
- Assess the flooding, inundation, and wave action damage risks relating to the coastal structure over its expected life or 50 years, whichever is less; and
- Provide alternatives for the coastal structure's design and siting, and how such alternatives would impact certain public health and environmental risks as well as the risk and cost associated with maintaining, repairing, and constructing the coastal structure.

If a governmental entity commences construction of a state-funded coastal structure but has not conducted the SLIP study, the bill authorizes DEP to institute a civil action to seek injunctive relief to cease further construction of the coastal structure or enforce compliance or, if the coastal structure has been completed or substantially completed, seek recovery of all or a portion of the state funds expended on the coastal structure.

The bill specifies that the failure to implement what is discussed in the SLIP study does not create a cause of action for damages or otherwise authorize the imposition of penalties by a public entity.

The bill may have an indeterminate negative fiscal impact on DEP because it requires DEP to conduct rulemaking and implement new regulations. The proposed House of Representatives' Fiscal Year 2020-2021 General Appropriations Act appropriates $6,000,353 within DEP for the Florida Resilient Coastline Initiative, so DEP can implement the rulemaking and new regulations within existing resources. There may also be an indeterminate positive fiscal impact on state and local governments in the long-term to conduct a SLIP study.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Sea-Level Rise and Coastal Flooding

With 1,350 miles of coastline and relatively low elevations, Florida is particularly vulnerable to coastal flooding.[1] One of the primary ways that climate change influences coastal flooding is through sea-level rise.[2] Sea-level rise is an observed increase in the average local sea level or global sea level trend.[3]

The two major causes of global sea-level rise are thermal expansion caused by the warming of the oceans and the loss of land-based ice due to melting.[4] Since 1880, the average global sea level has risen approximately eight to nine inches, and the rate of global sea-level rise has been accelerating.[5] The National Oceanic and Atmospheric Administration (NOAA) utilizes tide gauges to measure changes in sea level and provides data on local sea-level rise trends.[6] Analysis of this data shows that some low-lying areas in the southeastern United States experience higher local rates of sea-level rise than the global average.[7]

Florida's coastal communities are experiencing high-tide flooding events with increasing frequency because sea-level rise increases the height of high tides.[8] In the U.S., sea-level rise and flooding threaten an estimated $1 trillion in coastal real estate value, and analysts estimate that Florida could lose more than $300 billion in property value by 2100.[9] Sea-level rise further affects the salinity of both surface water and groundwater through saltwater intrusion, posing a risk particularly for shallow coastal aquifers.[10] Sea-level rise also pushes saltwater further upstream in tidal rivers and streams, raises coastal groundwater tables, and pushes saltwater further inland at the margins of coastal wetlands.[11]

Storm surge intensity and the intensity and precipitation rates of hurricanes are generally projected to increase,[12] and higher sea levels will cause storm surges to travel farther inland and impact more properties than in the past.[13] Stronger storms and sea-level rise are likely to lead to increased coastal erosion.[14]

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[1] Florida Division of Emergency Management, *Enhanced State Hazard Mitigation Plan, State of Florida* [hereinafter "SHMP"] (2018), 107-108, 162, available at https://www.floridadisaster.org/globalassets/dem/mitigation/mitigate-fl--shmp/shmp-2018-full_final_approved.6.11.2018.pdf (last visited Jan. 27, 2020). This measurement of Florida's coastline increases to over 8,000 miles when considering the intricacies of Florida's coastline, including bays, inlets, and waterways.

[2] *Id.* at 107.

[3] DEP, *Florida Adaptation Planning Guidebook: Glossary* [hereinafter "DEP Guidebook"] (2018), available at https://floridadep.gov/sites/default/files/AdaptationPlanningGuidebook.pdf (last visited Jan. 27, 2020).

[4] National Aeronautics and Space Administration (NASA), *Facts: Sea Level,* available at https://climate.nasa.gov/vital-signs/sea-level/ (last visited Jan. 27, 2020).

[5] U.S. Global Change Research Program, *Fourth National Climate Assessment* [hereinafter "NCA4"] (2018), 757, available at https://nca2018.globalchange.gov/downloads/NCA4_2018_FullReport.pdf (last visited Jan. 27, 2020).

[6] NOAA, *What is a Tide Gauge?*, available at https://oceanservice.noaa.gov/facts/tide-gauge.html (last visited Jan. 27, 2020); NOAA, Tides and Currents, *Sea Level Trends*, available at https://tidesandcurrents.noaa.gov/sltrends/ (last visited Jan. 27, 2020).

[7] NCA4 at 757.

[8] SHMP at 108, 101; NOAA, *High-Tide Flooding*, available at https://toolkit.climate.gov/topics/coastal-flood-risk/shallow-coastal-flooding-nuisance-flooding (last visited Jan. 27, 2020).

[9] NCA4 at 324, 758.

[10] SHMP at 106.

[11] *Id.* at 108.

[12] SHMP at 106, 141; NCA4 at 95, 97, 116-117, 1482.

[13] NCA4 at 758; SHMP at 107.

[14] NCA4 at 331, 340-341, 833, 1054, 1495; SHMP at 108, 221.

Increases in evaporation rates and water vapor in the atmosphere increase rainfall intensity and extreme precipitation events, and the sudden onset of water can overwhelm stormwater infrastructure.[15] As sea levels and groundwater levels rise, low areas drain more slowly, and the combined effects of rising sea levels and extreme rainfall events are increasing the frequency and magnitude of coastal and lowland flood events.[16]

State, Regional, and Local Programs

Many state, regional, and local programs and policies are in place that address issues relating to sea-level rise and coastal flooding. For example, the Department of Environmental Protection's (DEP) Office of Resilience and Coastal Protection implements numerous programs related to sea-level rise and coastal issues, including the Coastal Construction Control Line Program and the Beach Management Funding Assistance Program.[17] DEP also implements the Florida Resilient Coastlines Program, which helps prepare coastal communities and habitats for the effects of climate change, especially sea-level rise, by offering technical assistance and funding to communities dealing with coastal flooding, erosion, and ecosystem changes.[18]

On the regional level, through a collaboration to address climate change, the four counties of Broward, Miami-Dade, Monroe, and Palm Beach formed the Southeast Florida Regional Climate Change Compact (Compact).[19] The Compact's work includes developing a Regional Climate Action Plan and developing a Unified Sea-Level Rise Projection.[20] Many local governments in southeast Florida have since incorporated the Compact's projections into their planning documents and policies.[21]

Florida's local governments in coastal areas are required to have a coastal management element in their comprehensive plans that uses principles to reduce flood risk and eliminate unsafe development in coastal areas.[22] In certain coastal areas, local governments are further authorized to establish an "adaptation action area" designation in their comprehensive plan to develop policies and funding priorities that improve coastal resilience and plan for sea-level rise.[23]

Office of Resilience and Coastal Protection

In January of 2019, Governor DeSantis issued Executive Order 19-12, creating the Office of Resilience and Coastal Protection to help prepare Florida's coastal communities and habitats for impacts from sea-level rise by providing funding, technical assistance, and coordination among state, regional, and local entities.[24] In August of 2019, the Governor appointed Florida's first Chief Resilience Officer, who reports to the Executive Office of the Governor and collaborates with state agencies, local communities, and stakeholders to prepare for the impacts of sea-level rise and climate change.[25]

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[15] SHMP at 99, 106, 116, 141, 181; NCA4 at 88, 762-763.
[16] SHMP at 106; NCA4 at 763.
[17] DEP, *Beaches: About Us*, available at https://floridadep.gov/rcp/beaches (last visited Jan. 27, 2020).
[18] DEP, *Florida Resilient Coastlines Program*, available at https://floridadep.gov/rcp/florida-resilient-coastlines-program (last visited Jan. 27, 2020).
[19] Regional Climate Leadership Summit, *Southeast Florida Regional Climate Change Compact* (2010), available at http://southeastfloridaclimatecompact.org/wp-content/uploads/2014/09/compact.pdf (last visited Jan. 27, 2020); SFRCCC, *What is the Compact?*, available at http://southeastfloridaclimatecompact.org/about-us/what-is-the-compact/ (last visited Jan. 27, 2020).
[20] SFRCCC, *Regional Climate Action Plan*, available at http://southeastfloridaclimatecompact.org/regional-climate-action-plan/ (last visited Jan. 27, 2020).
[21] SFRCCC, *ST-1: Incorporate Projections into Plans*, available at http://southeastfloridaclimatecompact.org/recommendations/incorporate-projections-into-plans/ (last visited Jan. 27, 2020).
[22] Sections 380.24, 163.3177(6)(g), and 163.3178(2)(f), F.S.; *see* Ch. 2015-69, Laws of Fla.
[23] Sections 163.3177(6)(g)10. and 163.3164(1), F.S.; *see* Ch. 2011-139, Laws of Fla.
[24] Office of the Governor, *Executive Order Number 19-12*, 5 (2019), available at https://www.flgov.com/wp-content/uploads/2019/01/EO-19-12-.pdf (last visited Jan. 27, 2020).
[25] Governor Ron DeSantis, *News Releases: Governor Ron DeSantis Announces Dr. Julia Nesheiwat as Florida's First Chief Resilience Officer* (Aug. 1, 2019), available at https://flgov.com/2019/08/01/governor-ron-desantis-announces-dr-julia-nesheiwat-as-floridas-first-chief-resilience-officer/ (last visited Jan. 27, 2020).

Coastal Construction

Under current law, coastal construction is regulated by DEP in order to protect Florida's beaches and dunes from imprudent construction that can jeopardize the stability of the beach-dune system, accelerate erosion, provide inadequate protection to upland structures, endanger adjacent properties, or interfere with public beach access.[26] Coastal construction is defined as any work or activity likely to have a material physical effect on existing coastal conditions or natural shore and inlet processes.[27] Florida's coastal local governments may also establish coastal construction zoning and building codes in lieu of the statutory requirements as long as they are approved by DEP.[28]

The coastal construction control line (CCCL) defines the portion of the beach-dune system that is subject to severe fluctuations caused by a 100-year storm surge, storm waves, or other forces such as wind, wave, or water level changes.[29] A 100-year storm is a shore-incident hurricane or any other storm with accompanying wind, wave, and storm surge intensity that has a one percent chance of being equaled or exceeded in any given year.[30] Seaward of the CCCL, new construction and improvements to existing structures generally require a CCCL permit from DEP.[31] Due to the potential environmental impacts and greater risk of hazards from wind and flood, the standards for construction seaward of the CCCL are often more stringent than those that apply to the rest of the coastal building zone.[32] Permit applicants must show that the proposed project will not result in a significant adverse impact.[33] CCCLs are set by DEP on a county-wide basis and are currently established for the majority of Florida's coast.[34]

The "mean high-water line" is the point on the shore that marks the average height of the high waters over a 19-year period.[35] The mean high-water line is generally the boundary between the publicly-owned foreshore (the land alternately covered and uncovered by the tide) and the dry sand above the line, which may be privately owned.[36] Generally, construction is prohibited within 50 feet of the mean high-water line, known as the 50-foot setback.[37] Any structures below the mean high-water line that are determined by DEP to serve no public purpose; endanger human life, health, or welfare; or be undesirable or unnecessary must be adjusted, altered, or removed.[38]

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[26] Section 161.053(1)(a), F.S.

[27] Section 161.021(6), F.S.

[28] Section 161.053(3), F.S.

[29] Section 161.053, F.S.; r. 62B-33.005(1), F.A.C.; DEP, *The Homeowner's Guide to the Coastal Construction Control Line Program* (2017), 3, available at https://floridadep.gov/sites/default/files/Homeowner%27s%20Guide%20to%20the%20CCCL%20Program%206_2012%20%28002%29_0.pdf (last visited Jan. 27, 2020).

[30] Rule 62B-33.002(41), F.A.C.

[31] Section 161.053, F.S.; chs. 62B-33 and 62B-34, F.A.C.; DEP, *The Homeowner's Guide to the Coastal Construction Control Line Program* (2017), 3, available at https://floridadep.gov/sites/default/files/Homeowner%27s%20Guide%20to%20the%20CCCL%20Program%206_2012%20%28002%29_0.pdf (last visited Jan. 27, 2020); DEP, *ASK - Have Questions about the Coastal Construction Control Line (CCCL)?*, available at https://floridadep.gov/water/coastal-construction-control-line/content/ask-have-questions-about-coastal-construction (last visited Jan. 27, 2020).

[32] Chapter 62B-33, F.A.C.

[33] Rule 62B-33.005, F.A.C.

[34] Section 161.053(2), F.S.; DEP Geospatial Open Data, *Coastal Construction Control Lines (CCCL)*, http://geodata.dep.state.fl.us/datasets/4674ee6d93894168933e99aa2f14b923_2?geometry=-102.41%2C25.011%2C-60.596%2C31.77 (last visited Jan. 27, 2020).

[35] Section 177.27(14), (15), F.S.

[36] Section 177.28, F.S.; **ss.** 161.052(1), 161.151(3), 161.161(3)-(5), and 161.191, F.S. Where an "erosion control line" is established, it serves as the mean high-water line when it is landward of the existing mean high-water line, and all lands seaward of a recorded erosion control line are deemed to be vested in the state.

[37] Rule 62B-33.002(17), F.A.C.

[38] Section 161.061, F.S.

Above the mean high-water line is the "seasonal high-water line," which accounts for variations in the local mean high water, such as spring tides that occur twice per month.[39] The seasonal high-water line is used to create 30-year erosion projections of long-term shoreline recession based on historical measurements.[40] DEP makes 30-year erosion projections of the location of the seasonal high-water line on a site-specific basis upon receipt of a CCCL permit application.[41] With certain exceptions, DEP and local governments may not issue CCCL permits for the construction of major structures that are seaward of the 30-year erosion projection.[42]

The Coastal Zone Protection Act

The Legislature enacted the Coastal Zone Protection Act of 1985 (act) to minimize the impacts that activities or construction near the coast have on Florida's coastal areas.[43] The act imposes strict construction standards in Florida's coastal areas to protect the natural environment, private property, and life.[44] The act applies to activities and construction within the coastal building zone, an area stretching landward from the seasonal high-water line to a line 1,500 feet landward from the CCCL.[45]

The act generally requires construction to be located a sufficient distance landward of the beach to allow natural shoreline fluctuations and preserve dune stability.[46] Nonhabitable major structures[47] and minor structures[48] must be designed to produce the minimum adverse impact on the beach and dune system.[49] Minor structures must be designed to produce the minimum adverse impact to adjacent properties and reduce the potential for water or wind blown material.[50]

At or prior to the time that a contract is executed for the sale of real property located partially or totally seaward of the CCCL, the seller must give a prospective purchaser a written disclosure statement that states that the property may be subject to coastal erosion and to federal, state, and local regulations that govern coastal property.[51] The disclosure statement must indicate that additional information can be obtained from DEP on whether significant erosion conditions are associated with the shoreline of the property being purchased.

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[39] Section 161.053(5)(a)2., F.S., defines "seasonal high-water line" to mean the line formed by the intersection of the rising shore and the elevation of 150 percent of the local mean tidal range above local mean high water; NOAA, *What Are Spring and Neap Tides?*, available at https://oceanservice.noaa.gov/facts/springtide.html (last visited Jan. 27, 2020).

[40] Rules 62B-33.024, F.A.C.

[41] *Id.*

[42] Section 161.053(5), F.S.; DEP, *The Homeowner's Guide to the Coastal Construction Control Line Program* (2017), 6, available at https://floridadep.gov/sites/default/files/Homeowner%27s%20Guide%20to%20the%20CCCL%20Program%206_2012%20%28002%29_0.pdf (last visited Jan. 27, 2020).

[43] Sections 161.52-161.58, F.S.

[44] Section 161.53(1),(4), and (5), F.S.

[45] Section 161.54(1), F.S.; s. 161.55(4), F.S. On coastal barrier islands, the coastal building zone stretches 5,000 feet landward from the CCCL.

[46] Section 161.55(3), F.S. The act makes exceptions for certain structures such as piers, beach access ramps, or shore protection structures.

[47] Section 161.54(6)(a), F.S., defines "major structure" to mean houses, mobile homes, apartment buildings, condominiums, motels, hotels, restaurants, towers, other types of residential, commercial, or public buildings, and other construction having the potential for substantial impact on coastal zones. Section 161.54(6)(c), F.S., defines "nonhabitable major structure" to mean swimming pools; parking garages; pipelines; piers; canals, lakes, ditches, drainage structures, and other water retention structures; water and sewage treatment plants; electrical power plants, and all related structures or facilities, transmission lines, distribution lines, transformer pads, vaults, and substations; roads, bridges, streets, and highways; and underground storage tanks.

[48] Section 161.54(6)(b), F.S., defines "minor structure" to mean pile-supported, elevated dune and beach walkover structures; beach access ramps and walkways; stairways; pile-supported, elevated viewing platforms, gazebos, and boardwalks; lifeguard support stands; public and private bathhouses; sidewalks, driveways, parking areas, shuffleboard courts, tennis courts, handball courts, racquetball courts, and other uncovered paved areas; earth retaining walls; and sand fences, privacy fences, ornamental walls, ornamental garden structures, aviaries, and other ornamental construction.

[49] Sections 161.55(1) and 161.55(2), F.S.

[50] Section 161.55(1), F.S.

[51] Section 161.57(2), F.S.

Effect of the Bill

The bill defines the terms:

- "Coastal structure" to mean a major structure or nonhabitable major structure within the coastal building zone;
- "Public entity" to mean the state or any of its political subdivisions, or any municipality, county, agency, special district, authority, or other public body corporate of the state that is demonstrated to perform a public function or to serve a governmental purpose that could properly be performed or served by an appropriate governmental unit;
- "SLIP study" to mean a sea level impact projection study as established by DEP;
- "State-financed constructor" to mean a public entity that commissions or manages a construction project using funds appropriated from the state; and
- "Substantial flood damage" to mean flood, inundation, or wave action damage resulting from a single event, such as a flood or tropical weather system, where such damage exceeds 25 percent of the market value of the coastal structure at the time of the event;

The bill prohibits a state-financed constructor from commencing construction of a coastal structure unless the constructor has conducted a SLIP study, submitted the SLIP study to DEP, and received notification from DEP that the SLIP study was received and has been published on DEP's website. The bill requires DEP to adopt by rule a standard by which a state-financed constructor must conduct the SLIP study and authorizes the department to require that a professional engineer sign off on the study. The standard adopted by DEP must require a state-financed constructor to:

- Use a systematic, interdisciplinary, and scientifically accepted approach in the natural sciences and construction design in conducting the SLIP study;
- Assess the flooding, inundation, and wave action damage risks relating to the coastal structure over its expected life or 50 years, whichever is less; and
- Provide alternatives for the coastal structure's design and siting, and how such alternatives would impact certain public safety and environmental risks as well as the risk and cost associated with maintaining, repairing, and constructing the coastal structure.

The bill specifically requires the assessment of risks conducted by the state-financed constructor to:

- Take into account potential relative local sea level rise and increased storm risk during the expected life of the coastal structure or 50 years, whichever is less, and, to the extent possible, account for the contribution of sea level rise versus land subsidence to the relative local sea level rise;
- Provide scientific and engineering evidence of the risk to the coastal structure and methods used to mitigate, adapt to, or reduce this risk;
- Use and consider available scientific research and generally accepted industry practices;
- Provide the mean average annual chance of substantial flood damage over the expected life of the coastal structure or 50 years, whichever is less; and
- Analyze potential public safety and environmental impacts resulting from damage to the coastal structure, including leakage of pollutants, electrocution and explosion hazards, and hazards resulting from floating or flying structural debris.

The bill specifies that the state-financed constructor is solely responsible for ensuring that the SLIP study submitted to DEP for publication meets these requirements. The bill requires DEP to publish and maintain a copy of all SLIP studies submitted for at least 10 years after receipt once any information exempt from public record requirements has been redacted.

The bill specifies that if multiple coastal structures are to be built concurrently within one project, a state-financed constructor may conduct and submit one SLIP study for the entire project.

If a state-financed constructor commences construction of a coastal structure but has not conducted the SLIP study, the bill authorizes DEP to institute a civil action to seek injunctive relief to cease further

construction of the coastal structure or enforce compliance or, if the coastal structure has been completed or substantially completed, to seek recovery of all or a portion of the state funds expended on the coastal structure.

The bill specifies that the failure to implement what is contained in the SLIP study does not create a cause of action for damages or otherwise authorize the imposition of penalties by a public entity.

B. SECTION DIRECTORY:

Section 1. Creates s. 161.551, F.S., relating to public financing of construction projects within the coastal building zone.

Section 2. Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill may have an indeterminate negative fiscal impact on state government because the bill requires governmental entities to conduct a SLIP study prior to construction of certain coastal structures in the short-term. The SLIP study will identify risks that could potentially avoid damage and loss of coastal structures that were constructed using state funds, so the bill may result in an indeterminate positive fiscal impact to state government in the long-term.

The bill may have an indeterminate negative fiscal impact on DEP because it requires DEP to conduct rulemaking and implement new regulations. The proposed House of Representatives' Fiscal Year 2020-2021 General Appropriations Act appropriates $6,000,353 ($5,500,353 in recurring funding) within DEP for the Florida Resilient Coastline Initiative, so DEP can implement the rulemaking and new regulations within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The bill may have an indeterminate negative fiscal impact on local governments because the bill requires governmental entities to conduct a SLIP study prior to construction of certain coastal structures. The SLIP study will identify risks that could potentially avoid damage and loss of coastal structures, so the bill may result in an indeterminate positive fiscal impact to local governments in the long-term.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill requires DEP to adopt rules to establish requirements for the SLIP study.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Agriculture & Natural Resources Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment required the assessment of risks to take into account potential relative local sea level rise and the contribution of land subsidence to the relative local sea level rise. The amendment also specified that the failure to implement what is contained in the SLIP study does not create a cause of action for damages or authorize the imposition of penalties.

This analysis is drafted to the committee substitute as approved by the Agriculture & Natural Resources Subcommittee.

A bill to be entitled

An act relating to public financing of construction projects; creating s. 161.551, F.S.; providing definitions; prohibiting state-financed constructors from commencing construction of certain structures in coastal areas without first conducting a sea level impact projection study; requiring the Department of Environmental Protection to develop by rule a standard for such studies; requiring the department to publish such studies on its website, subject to certain conditions; providing construction; requiring the department to enforce certain requirements and to adopt rules; providing for enforcement; providing an effective date.

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

Section 1. Section 161.551, Florida Statutes, is created to read:

161.551 Public financing of construction projects within the coastal building zone.—

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

(a) "Coastal structure" means a major structure or nonhabitable major structure within the coastal building zone.

(b) "Public entity" means the state or any of its

political subdivisions, or any municipality, county, agency, special district, authority, or other public body corporate of the state which is demonstrated to perform a public function or to serve a governmental purpose that could properly be performed or served by an appropriate governmental unit.

(c) "SLIP study" means a sea level impact projection study as established by the department pursuant to subsection (3).

(d) "State-financed constructor" means a public entity that commissions or manages a construction project using funds appropriated from the state.

(e) "Substantial flood damage" means flood, inundation, or wave action damage resulting from a single event, such as a flood or tropical weather system, where such damage exceeds 25 percent of the market value of the coastal structure at the time of the event.

(2) A state-financed constructor may not commence construction of a coastal structure without:

(a) Conducting a SLIP study that meets the requirements established by the department;

(b) Submitting the study to the department; and

(c) Receiving notification from the department that the study was received and that it has been published on the department's website pursuant to paragraph (6)(a) for at least 30 days. The state-financed constructor is solely responsible for ensuring that the study submitted to the department for

publication meets the requirements under subsection (3).

(3) The department shall develop by rule a standard by which a state-financed constructor must conduct a SLIP study and may require that a professional engineer sign off on the study. At a minimum, the standard must require that a state-financed constructor do all of the following:

(a) Use a systematic, interdisciplinary, and scientifically accepted approach in the natural sciences and construction design in conducting the study.

(b) Assess the flooding, inundation, and wave action damage risks relating to the coastal structure over its expected life or 50 years, whichever is less.

1. The assessment must take into account potential relative local sea level rise and increased storm risk during the expected life of the coastal structure or 50 years, whichever is less, and, to the extent possible, account for the contribution of sea level rise versus land subsidence to the relative local sea level rise.

2. The assessment must provide scientific and engineering evidence of the risk to the coastal structure and methods used to mitigate, adapt to, or reduce this risk.

3. The assessment must use and consider available scientific research and generally accepted industry practices.

4. The assessment must provide the mean average annual chance of substantial flood damage over the expected life of the

coastal structure or 50 years, whichever is less.

5. The assessment must analyze potential public safety and environmental impacts resulting from damage to the coastal structure including, but not limited to, leakage of pollutants, electrocution and explosion hazards, and hazards resulting from floating or flying structural debris.

(c) Provide alternatives for the coastal structure's design and siting, and how such alternatives would impact the risks specified in subparagraph (b)5. as well as the risk and cost associated with maintaining, repairing, and constructing the coastal structure.

If multiple coastal structures are to be built concurrently within one project, a state-financed constructor may conduct and submit one SLIP study for the entire project for publication by the department.

(4) If a state-financed constructor commences construction of a coastal structure but has not complied with the SLIP study requirement under subsection (2), the department may institute a civil action in a court of competent jurisdiction to:

(a) Seek injunctive relief to cease further construction of the coastal structure or enforce compliance with this section or with rules adopted by the department pursuant to this section.

(b) If the coastal structure has been completed or has

been substantially completed, seek recovery of all or a portion of state funds expended on the coastal structure.

(5) This section may not be construed to create a cause of action for damages or otherwise authorize the imposition of penalties by a public entity for failure to implement what is contained in the SLIP study.

(6) The department:

(a) Shall publish and maintain a copy of all SLIP studies submitted pursuant to this section on its website for at least 10 years after receipt. However, any portion of a study containing information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution must be redacted by the department before publication.

(b) Shall adopt rules as necessary to administer this section.

(7) The department may enforce the requirements of this section.

Section 2. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 605 Senior Management Service Class
SPONSOR(S): Oversight, Transparency & Public Management Subcommittee; Pritchett; Plakon; and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 952

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Oversight, Transparency & Public Management Subcommittee	12 Y, 0 N, As CS	Toliver	Smith
2) Appropriations Committee		Keith	Pridgeon
3) State Affairs Committee			

SUMMARY ANALYSIS

In 2007, the Legislature established five Offices of Criminal Conflict and Civil Regional Counsel. When an Office of the Public Defender determines it has a conflict in representing an indigent defendant, the Office of Criminal Conflict and Civil Regional Counsel will be appointed to represent the defendant. The Office of Criminal Conflict and Civil Regional Counsel has primary responsibility for representing persons entitled to court-appointed counsel under the Federal or State Constitution or as authorized by law in civil proceedings, such as proceedings to terminate parental rights. The Governor appoints each Regional Counsel for a term of four years, subject to Senate confirmation.

The Florida Retirement System (FRS) is a contributory retirement system, with active members contributing 3.0 percent of their salaries. FRS Members have two primary plan options available for participation: the defined benefit plan, also known as the pension plan, and the defined contribution plan, also known as the investment plan. The membership of the FRS is divided into five membership classes:

- The Regular Class;
- The Special Risk Class;
- The Special Risk Administrative Support Class;
- The Elected Officers' Class; and
- The Senior Management Service Class (SMSC).

Benefits payable under the pension plan are calculated based on the member's years of creditable service multiplied by the service accrual rate multiplied by the member's average final compensation. The Regular Class service credit provides a 1.6 percent accrual value for each year of creditable service while the SMSC earns a 2.0 percent accrual value each year.

Benefits under the investment plan accrue in individual member accounts funded by both employee and employer contributions and investment earnings. Benefits are provided through employee-directed investments offered by approved investment providers. The amount of money contributed to each member's account varies by class with the Regular Class receiving 6.3 percent and SMSC receiving 7.67 percent.

The bill makes certain managerial employees of the Criminal Conflict and Civil Regional Counsel offices members of the SMSC (rather than the Regular Class) of the FRS. For each employee participating in the pension plan, this shift means the employee earns 2.0 percent service credit for each year of service rather than 1.6 percent. For an employee participating in the investment plan, the employee will receive contributions into the investment account equal to 7.67 percent of salary rather than 6.3 percent. Any employee shifted from the Regular Class to the SMSC is permitted to upgrade retirement credit for service in the same position.

The bill would have a significant fiscal impact on state government expenditures.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Criminal Conflict and Civil Regional Counsel

In 2007, the Legislature established five offices of Criminal Conflict and Civil Regional Counsel.[1] When an Office of the Public Defender determines it has a conflict in representing an indigent defendant, the Office of Criminal Conflict and Civil Regional Counsel will be appointed to represent the defendant. The Office of Criminal Conflict and Civil Regional Counsel has primary responsibility for representing persons entitled to court-appointed counsel under the Federal or State Constitution or as authorized by law in civil proceedings, such as proceedings to terminate parental rights.[2] Each regional counsel is recommended as part of list of qualified candidates by the Supreme Court Judicial Nominating Commission.[3] Thereafter, the Governor appoints the regional counsel from amongst those listed for a term of four years.[4] The appointment is subject to Senate confirmation.[5] Each office of criminal conflict and civil regional counsel is housed, for administrative purposes, in the Justice Administrative Commission.[6] Regional counsels serve on a full-time basis and may not engage in the private practice of law while holding office.[7]

The table below shows the number of full-time equivalent positions and the amount of salary rate authorized for each of the five regional offices.

Regional Office	FTE Positions	Salary Rate
First	122.00	6,822,226
Second	107.00	6,310,604
Third	66.75	4,314,054
Fourth	114.00	6,257,822
Fifth	92.00	4,621,667
Total	501.75	28,326,373

The Florida Retirement System

The Florida Retirement System (FRS) was established in 1970 when the Legislature consolidated the Teachers' Retirement System, the State and County Officers and Employees' Retirement System, and the Highway Patrol Pension Fund. In 1972, the Judicial Retirement System was consolidated into the FRS, and in 2007, the Institute of Food and Agricultural Sciences Supplemental Retirement Program was consolidated under the Regular Class of the FRS as a closed group.[8] The FRS is a contributory system, with active members contributing three percent of their salaries. It is the primary retirement plan for employees of state and county government agencies, district school boards, state colleges, and universities.

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[1] Section 27.511(1), F.S.
[2] Section 27.511(5) and (6), F.S.
[3] Section 27.511(3)(a), F.S.
[4] *Id.*
[5] *Id.*
[6] Section 27.511(2), F.S.
[7] Section 27.511(4), F.S.
[8] Florida Retirement System Pension Plan and Other State Administered Retirement Systems Comprehensive Annual Financial Report Fiscal Year Ended June 30, 2019, at p. 35, available at https://www.rol.frs.state.fl.us/forms/2018-19_CAFR.pdf (last visited January 24, 2020).

The membership of the FRS is divided into five membership classes:

- The Regular Class[9] consists of 554,631 active members and 7,629 in renewed membership;
- The Special Risk Class[10] includes 74,274 active members and 1,112 in renewed membership;
- The Special Risk Administrative Support Class[11] has 100 active members and 1 in renewed membership;
- The Elected Officers' Class[12] has 2,088 active members and 112 in renewed membership; and
- The Senior Management Service Class[13] has 7,767 active members and 214 in renewed membership.[14]

Members of the FRS have two primary plan options available for participation:

- The defined benefit plan, also known as the pension plan; and
- The defined contribution plan, also known as the investment plan.

Pension Plan

The pension plan is administered by the secretary of the Department of Management Services through the Division of Retirement.[15] Investment management is handled by the State Board of Administration.

Any member initially enrolled in the pension plan before July 1, 2011, vests in the pension plan after completing six years of service with an FRS employer.[16] For members initially enrolled on or after July 1, 2011, the member vests in the pension plan after eight years of creditable service.[17] Benefits payable under the pension plan are calculated based on the member's years of creditable service multiplied by the service accrual rate multiplied by the member's average final compensation.[18] For most current members of the pension plan (including members in the Regular Class and the Senior Management Service Class), normal retirement (when first eligible for unreduced benefits) occurs at the earliest attainment of 30 years of service or age 62.[19] Members initially enrolled in the pension plan on or after July 1, 2011, have longer service requirements. For members initially enrolled after that date, a member in the Regular Class or the Senior Management Service Class (SMSC) must complete 33 years of service or attain age 65.[20]

The Regular Class and the SMSC share the same normal retirement dates, average final compensation calculation, and disability/survivor benefits. However, the Regular Class service credit provides a 1.6 percent accrual value for each year of creditable service while the SMSC earns a 2.0 percent accrual value each year.[21]

A member of the SMSC may upgrade service credit in the same position from Regular Class accrual value to the SMSC accrual value.[22] Generally, the service credit may be purchased by the employer on behalf of the member.[23]

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[9] The Regular Class is for all members who are not assigned to another class. Section 121.021(12), F.S.
[10] The Special Risk Class is for members employed as law enforcement officers, firefighters, correctional officers, probation officers, paramedics and emergency technicians, among others. Section 121.0515, F.S.
[11] The Special Risk Administrative Support Class is for a special risk member who moved or was reassigned to a nonspecial risk law enforcement, firefighting, correctional, or emergency medical care administrative support position with the same agency, or who is subsequently employed in such a position under the Florida Retirement System. Section 121.0515(8), F.S.
[12] The Elected Officers' Class is for elected state and county officers, and for those elected municipal or special district officers whose governing body has chosen Elected Officers' Class participation for its elected officers. Section 121.052, F.S.
[13] The Senior Management Service Class is for members who fill senior management level positions assigned by law to the Senior Management Service Class or authorized by law as eligible for Senior Management Service designation. Section 121.055, F.S.
[14] *Supra* note 8 at pg. 161.
[15] Section 121.025, F.S.
[16] Section 121.021(45)(a), F.S.
[17] Section 121.021(45)(b), F.S.
[18] Section 121.091, F.S.
[19] Section 121.021(29)(a)1., F.S.
[20] Sections 121.021(29)(a)2. and (b)2., F.S.
[21] Section 121.091(1)(a), F.S.
[22] Section 121.055(1)(j), F.S.
[23] *Id.*

Investment Plan

In 2000, the Public Employee Optional Retirement Program (investment plan) was created as a defined contribution plan offered to eligible employees as an alternative to the FRS Pension Plan.[24] The State Board of Administration (SBA) is primarily responsible for administering the investment plan.[25] The Board of Trustees of the SBA is comprised of the Governor as chair, the Chief Financial Officer, and the Attorney General.[26]

Benefits under the investment plan accrue in individual member accounts funded by both employee and employer contributions and earnings.[27] Benefits are provided through employee-directed investments offered by approved investment providers.[28]

A member vests immediately in all employee contributions paid to the investment plan.[29] With respect to the employer contributions, a member vests after completing one work year of employment with an FRS employer.[30] Vested benefits are payable upon termination or death as a lump-sum distribution, direct rollover distribution, or periodic distribution.[31] The investment plan also provides disability coverage for both in-line-of-duty and regular disability retirement benefits.[32] An FRS member who qualifies for disability while enrolled in the investment plan may apply for benefits as if the employee were a member of the pension plan. If approved for retirement disability benefits, the member is transferred to the pension plan.[33]

The table below shows the allocation of contributions made into the FRS for members of the investment plan participating in the Regular Class and SMSC. The contributions are based on a percentage of the member's gross compensation for the month.

Allocation of Contributions	Regular Class	SMSC
Investment Account	6.30%	7.67%
Disability	0.25%	0.26%
In line of duty death	0.05%	0.05%
Administrative Assessments	0.06%	0.06%
Total	6.66%	8.04%

Effect of the bill

The bill makes certain managerial employees of the Criminal Conflict and Civil Regional Counsel Offices members of the SMSC, rather than the Regular Class, of the FRS. For each employee participating in the pension plan of the FRS, this shift means the employee earns 2.0 percent service credit for each year of service rather than 1.6 percent. For an employee participating in the investment plan of the FRS, the employee will receive contributions into the investment account equal to 7.67 percent of salary rather than 6.3 percent. Any employee shifted from the Regular Class to the SMSC is

[24] Section 121.4501(1), F.S.
[25] Section 121.4501(8), F.S.
[26] Article IV, s. 4(e), FLA. CONST.
[27] Section 121.4501(1), F.S.
[28] *Id.*
[29] Section 121.4501(6)(a), F.S.
[30] If a member terminates employment before vesting in the investment plan, the nonvested money is transferred from the member's account to the SBA for deposit and investment by the SBA in its suspense account for up to five years. If the member is not reemployed as an eligible employee within five years, then any nonvested accumulations transferred from a member's account to the SBA's suspense account are forfeited. Section 121.4501(6)(b)-(d), F.S.
[31] Section 121.591, F.S.
[32] *See* s. 121.4501(16), F.S.
[33] Pension plan disability retirement benefits, which apply for investment plan members who qualify for disability, compensate an in-line-of-duty disabled member up to 65 percent of the average monthly compensation as of the disability retirement date for special risk class members. Other members may receive up to 42 percent of the member's average monthly compensation for disability retirement benefits. If the disability occurs other than in the line of duty, the monthly benefit may not be less than 25 percent of the average monthly compensation as of the disability retirement date. Section 121.091(4)(f), F.S.

permitted to upgrade retirement credit for service in the same position. The upgraded service credit may not be purchased by the member's employer.

B. SECTION DIRECTORY:

Section 1: Amends s. 121.055, F.S., relating to the Senior Management Service Class.

Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill would have a significant fiscal impact on state expenditures.

   The state contributes per pay period an amount equivalent to 8.47% of the salary for each Regular Class member's salary into the FRS. The state contributes per pay period an amount equivalent to 25.48% of the salary for each Senior Management Service Class member's salary.

   The FRS membership class change would apply to 20 current positions in the five offices of the Criminal Conflict and Civil Regional Counsels. Employer contributions would increase by approximately $290,000, which would be paid annually beginning in the 2020-2021 fiscal year.[34] These funds will be deposited into the FRS Trust Fund to be used to pay benefits upon each member's retirement.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

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[34] Offices of Criminal Conflict and Civil Regional Counsel, Agency Analysis of 2020 House Bill 605, p.3 (Jan. 27, 2020)

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not confer rulemaking authority nor does it require the promulgation of rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 29, 2020, the Oversight, Transparency & Public Management Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment removed the provision of the bill granting discretion to each of the Criminal Conflict and Civil Regional Counsel Offices to designate up to an additional five percent of its employees to the SMSC. The amendment also altered the retroactive date to which a person was permitted to upgrade retirement credit for service in the same position from February 1, 1987 to October 1, 2007, as that is the date of the creation of the offices of Criminal Conflict and Civil Regional Counsel.

This analysis is drafted to the committee substitute as approved by the Oversight, Transparency & Public Management Subcommittee.

A bill to be entitled

An act relating to the Senior Management Service Class; amending s. 121.055, F.S.; providing that participation in the Senior Management Service Class of the Florida Retirement System is compulsory for certain persons on a specified date; authorizing members of such class to purchase and upgrade certain retirement credit; providing an effective date.

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

Section 1. Paragraph (m) is added to subsection (1) of section 121.055, Florida Statutes, to read:

121.055 Senior Management Service Class.—There is hereby established a separate class of membership within the Florida Retirement System to be known as the "Senior Management Service Class," which shall become effective February 1, 1987.

(1)

(m)1. Effective July 1, 2020, participation in the Senior Management Service Class is compulsory for each appointed criminal conflict and civil regional counsel and each district's assistant regional counsel chiefs, administrative directors, and chief investigators.

2. A member under this paragraph of the Senior Management Service Class may purchase additional retirement credit in such

class for creditable service within the purview of the Senior Management Service Class retroactive to October 1, 2007, and may upgrade retirement credit for such service in accordance with paragraph (j). However, this service credit may not be purchased by the employer on behalf of the member.

Section 2. This act shall take effect July 1, 2020.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

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

Amendment (with title amendment)

Between lines 30 and 31, insert:

Section 2. For the 2020-2021 fiscal year, the sum of $288,234 in recurring funds is appropriated from the General Revenue Fund to the offices of the Criminal Conflict and Civil Regional Counsels for the purpose of making retirement benefits payments for specified positions within those offices.

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

Remove line 8 and insert:

Retirement credit; providing appropriations; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 731 Agency for Health Care Administration
SPONSOR(S): Health Market Reform Subcommittee, Perez
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1726

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	11 Y, 1 N, As CS	Guzzo	Calamas
2) Appropriations Committee		Nobles JTN	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill amends various authorizing and licensing statutes for entities regulated by the Agency for Health Care Administration (AHCA), including, nurse registries, home medical equipment providers, health care clinics, nursing homes, assisted living facilities, diagnostic imaging centers, ambulatory surgical centers (ASCs), and home health agencies. Specifically the bill:

- Creates risk-based licensure inspections for nurse registries, home medical equipment providers, and health care clinics to provide AHCA the flexibility to inspect high-performing providers less frequently than poor performers;
- Allows AHCA to conduct extended inspection periods for other high performing providers that are currently required to be inspected biennially, including hospices and adult day care centers;
- Revises a requirement for AHCA to inspect nursing homes with records of poor performance every six months for a two year period, to instead, require AHCA to conduct one additional inspection;
- Creates an exemption to health care clinic licensure for federally certified providers, community mental health center-partial hospitalization programs, portable x-ray providers, and rural health clinics;
- Repeals licensure of multiphasic health testing centers;
- Allows AHCA to issue a provisional license to all regulated providers/facilities;
- Repeals several statutorily mandated annual reports that are obsolete or rarely used, and instead directs AHCA to publish the information online;
- Repeals an unenforceable annual assessment on diagnostic imaging centers and ASCs;
- Updates requirements for approval of comprehensive emergency management plans for newly licensed facilities to create a consistent approval process across all provider types;
- Removes the ability of a health care clinic to submit a surety bond instead of submitting certain documents as proof of financial ability to operate to satisfy initial licensure requirements;
- Removes outdated language relating to certificate of need, to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee;
- Amends the definition of home health agency by removing staffing services to clarify that a home health agency that provides only home health services, but not staffing services, is required to be licensed as a home health agency; and
- Creates an exemption from health care clinic licensure for all Medicaid providers.

The bill strengthens AHCA's authority to conduct retrospective review of Medicaid hospital payments to allow AHCA to recover all overpayments.

The bill also strengthens AHCA's ability to collect legal fees for Medicaid cases in which AHCA prevails.

The bill has an indeterminate, but likely insignificant, fiscal impact on AHCA (see fiscal comments).

The bill has no fiscal impact to local governments.

Except as otherwise expressly provided, the bill provides an effective date of July 1, 2020

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Agency for Health Care Administration – Division of Health Quality Assurance

The Division of Health Quality Assurance (HQA), housed within the Agency for Health Care Administration (AHCA), licenses, certifies, and regulates 40 different types of health care providers. In total, HQA regulates more than 48,000 individual providers.[1] Regulated providers include:

- Laboratories performing testing under the Drug-Free Workplace program, s. 440.102(9), F.S.
- Birth centers, ch. 383, F.S.
- Abortion clinics, ch.390, F.S.
- Crisis stabilization units, parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, part IV of ch. 394, F.S.
- Hospitals, part I of ch. 395, F.S.
- Ambulatory surgical centers, part I of ch. 395, F.S.
- Nursing homes, part II of ch. 400, F.S.
- Assisted living facilities (ALFs), part I of ch. 429, F.S.
- Home health agencies, part III of ch. 400, F.S.
- Nurse registries, part III of ch. 400, F.S.
- Companion services or homemaker services providers, part III of ch. 400, F.S.
- Adult day care centers, part III of ch. 429, F.S.
- Hospices, part IV of ch. 400, F.S.
- Adult family-care homes, part II of ch. 429, F.S.
- Homes for special services, part V of ch. 400, F.S.
- Transitional living facilities, part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, part VI of ch. 400, F.S.
- Home medical equipment providers, part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, part VIII of ch. 400, F.S.
- Health care services pools, part IX of ch. 400, F.S.
- Health care clinics, part X of ch. 400, F.S.
- Multiphasic health testing centers, part II of ch. 483, F.S.
- Organ, tissue, and eye procurement organizations, part V of ch. 765, F.S.

Certain health care providers[2] are regulated under part II of ch. 408, F.S., which is the Health Care Licensing Procedures Act (Act), or core licensing statutes. The Act provides uniform licensing procedures and standards for 26 provider types.[3] In addition to the Act, each provider type has an authorizing statute which includes unique provisions for licensure beyond the uniform criteria. In the case of conflict between the Act and an individual authorizing statute, the Act prevails.[4]

[1] Agency for Health Care Administration, *Health Quality Assurance*, 2017, available at http://ahca.myflorida.com/MCHQ/ (last visited January 31, 2020).
[2] "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.
[3] S. 408.802, F.S.
[4] S. 408.832, F.S.

Birth Centers

Current Situation

A birth center is any facility, institution, or place, which is not an ambulatory surgical center or a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.[5] Birth centers are licensed and regulated by AHCA under ch. 383, F.S., and part II of ch. 408, F.S.

AHCA is required to adopt rules establishing minimum standards for birth centers, which ensure:

- Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety;
- Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented; and
- Licensed facilities are established, organized, and operated consistent with established programmatic standards.[6]

Section 383.327, F.S., requires birth centers to submit an annual report to AHCA, the contents of which are to be prescribed by AHCA rule. Current law does not expressly authorize AHCA to adopt rules to change the frequency for submission of the report. Rule 59A-11.019, F.A.C., requires birth centers to submit the annual report using an electronic form, which includes reportable data fields on:

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reason for the transfer, whether it occurred intrapartum or postpartum, and the length of the hospital stay;
- Newborn transfers, including the reason for the transfer, birth weight, days in hospital, and APGAR score[7] at five and ten minutes;
- Newborn deaths; and
- Stillborn/Fetal deaths.[8]

Effect of the Bill

The bill amends s. 383.327, F.S., to remove the statutory requirement for the report to be submitted annually. Instead, the bill authorizes AHCA to adopt rules to establish the frequency at which the report is submitted. According to AHCA, this will allow the Agency to change the annual reporting requirement in AHCA rule to require more frequent submission.[9]

Birth centers are also required to immediately report each maternal death, newborn death, and stillbirth to the medical examiner. However, current law does not require birth centers to immediately report such deaths to AHCA. The bill requires birth centers to immediately report to AHCA each maternal death, newborn death, and stillbirth.

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[5] S. 383.302(2), F.S. Section 383.302(8), F.S.
[6] Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.
[7] The AGPAR score is the result of a test given by the delivering physician, midwife or nurse to measure a baby's heart rate, muscle tone, and other signs to determine if extra medical attention is needed. A newborn is scored on a scale of 0 to 2, with 2 being the best score for each of the following: appearance (skin color), pulse (heart rate), grimace response (reflexes), activity (muscle tone), and respiration (breathing rate).
[8] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Apr. 2019).
[9] Agency for Health Care Administration, 2020 Legislative Bill Analysis-HB 731, January 28, 2020 (on file with Health Market Reform Subcommittee staff).

Hospital Licensure

Current Situation

In 2019, the Legislature eliminated certificate of need review for general hospitals.[10] Section 395.003, F.S., requires AHCA to include certain information on a license issued to a hospital, including, the service categories and the number of hospital beds in each bed category. Current law in this section includes an outdated CON provision directing AHCA to identify hospital beds as general beds on the face of the hospital's license, when not covered by any specialty-bed-need methodology. Beds covered by a specialty-bed-need methodology include neonatal intensive care beds, comprehensive medical rehabilitation beds, adult psychiatric beds, child/adolescent psychiatric beds, and adult substance abuse beds. Currently, these specialty hospital beds might be incorrectly reported as general beds on the face of the hospital's license.

Effect of the Bill

The bill removes this obsolete language to allow hospital licenses to correctly reflect the actual bed categories provided by a licensee.

Annual Assessments on Health Care Facilities

Current Situation

Section 395.7015, F.S., imposes an annual assessment on ambulatory surgical centers and certain diagnostic imaging centers[11], to be deposited into the Public Medical Assistance Trust Fund (PMATF). These assessments were ruled unconstitutional in 2002, and are no longer collected.[12]

Effect of the Bill

The bill repeals s. 395.7015, F.S., to remove unenforceable statutory authority for AHCA to collect the annual assessments. The bill also amends s. 395.7016, F.S., to make a conforming change by removing a cross-reference to s. 395.7015, F.S.

Nursing Home Inspections

Current Situation

Uniform licensing requirements in s. 408.811, F.S., require all facilities licensed by AHCA to be inspected biennially unless otherwise specified in statute or rule.

Section 400.19, F.S., requires AHCA to conduct at least one unannounced inspection of licensed nursing homes every 15 months. Federal law also requires AHCA to inspect nursing homes every 15 months.[13]

Current law in s. 400.19, F.S., also requires AHCA to conduct additional inspections of nursing homes that are cited for multiple deficiencies within specified timeframes. Specifically, AHCA is required to inspect a nursing home every six months for two years if the facility has been cited for a class I

[10] Ch. 2019-136, L.O.F.
[11] Diagnostic imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services, and in which services are rendered by a licensed physician or a licensed osteopathic physician.
[12] *Agency for Health Care Administration v. Hameroff,* 816 So. 2d 1145, 1149-1150 (Fla. 1st DCA 2002).
[13] 42 C.F.R. §. 488.308(a).

deficiency[14], has been cited for two or more class II deficiencies[15] arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a six-month period that resulted in at least one class I or class II deficiency. Current law also requires nursing homes to pay a $6,000 fine for falling under the additional inspection cycle.

Effect of the Bill

The bill amends s. 400.19, F.S., to remove the 15-month inspection requirement. However, AHCA will still be required to inspect nursing homes every 15 months as required by federal law.

The bill revises the requirement for AHCA to additionally inspect nursing homes every six months for two years as detailed above. Instead, the bill requires AHCA to conduct one additional inspection under those circumstances.

Hospice Inspections

Current Situation

Section 400.605, F.S., requires AHCA to conduct annual inspections of hospices, with the exception that inspections may be conducted biennially for hospices having a three-year record of substantial compliance.

Effect of the Bill

The bill amends s. 400.605, F.S., removing the requirement for AHCA to inspect hospices annually, or biennially for hospices having a three-year record of substantial compliance. Instead, the bill requires AHCA to inspect hospices biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to a hospice, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

Adult Day Care Center Inspections

Current Situation

Adult day care centers are inspected biennially by AHCA in accordance with the uniform licensing requirements in s. 408.811, F.S. Adult day care center programs that are collocated in an ALF or a

[14] S. 408.813(2)(a), F.S. Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

[15] S. 408.813(2)(b), F.S. Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

nursing home are also required to be inspected biennially by AHCA pursuant to the adult day care center licensing statute in s. 429.905, F.S.

Section 429.929, F.S., authorizes AHCA to conduct, in lieu of a full inspection, an abbreviated biennial inspection of key quality of care standards if the adult day care center has a record of good performance.

Effect of the Bill

The bill amends s. 429.905, F.S., to remove the biennial inspection requirement for adult day care center programs collocated in an ALF or a nursing home. As a result, AHCA will be required to inspect adult day care center programs collocated in an ALF or a nursing home in accordance with the inspection requirements for ALFs and nursing homes. For nursing homes, the inspection frequency is once every 15 months. For adult day care centers collocated in an ALF, the inspections will be in accordance with the new ALF inspection requirements detailed in the ALF section above. This will have no measurable effect because both settings in which an adult day care center may be collocated will be inspected more frequently than biennially.

The bill removes the authority for AHCA to conduct abbreviated biennial inspections of adult days care centers. Instead, the bill requires AHCA to inspect adult day care centers biennially in accordance with the uniform licensing requirements in s. 408.811, F.S. In addition, the bill authorizes AHCA to conduct inspections less frequently than biennially. The bill requires AHCA to consider certain measures reflective of quality and safety in granting an extended inspection period to an adult day care center, including whether the facility has:

- A favorable regulatory history of deficiencies, sanctions, complaints, and other regulatory measures;
- Outcome measures that demonstrate quality performance;
- Successful participation in a recognized, quality program; and
- Accreditation status.

The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for the extended inspection period.

Inspections of Health Care Clinics, Home Medical Equipment Providers and Nurse Registries

Current Situation

Health care clinics, home medical equipment providers, and nurse registries are all subject to initial licensure inspections and biennial inspections pursuant to the uniform licensing requirements of s. 408.811, F.S.

According to AHCA, the inspection history for these three provider types have been good compared to other provider types, which indicates to AHCA that they are low-risk providers as compared to other providers.[16]

The results of inspections conducted during fiscal years 2017-18 and 2018-19, for these three provider types found that:

- 87 percent of health care clinics were deficiency free;
- 79 percent of home medical equipment providers were deficiency free; and
- 59 percent of nurse registries were deficiency free.[17]

[16] Id.
[17] Id.

Effect of the Bill

The bill exempts health care clinics, home medical equipment providers, and nurse registries from licensure inspections. Instead, the bill authorizes AHCA to conduct verification of compliance inspections for health care clinics, home medical equipment providers, and nurse registries. The bill requires AHCA to continue to conduct unannounced licensure inspections on at least 10 percent of providers to verify regulatory compliance. According to ACHA, this will provide the agency the flexibility to conduct fewer inspection visits to providers with a good regulatory history, and allow them to spend more time and resources inspecting poorly performing providers.[18]

Home Health Agencies

Current Situation

A "home health agency" is an organization that provides home health services and staffing services.[19] According to AHCA, there is concern that the definition could be interpreted to mean a provider is exempt from licensure as a home health agency if they provide home health services but not staffing services.[20]

Home health services are health and medical services and supplies furnished by an organization[21] to an individual in the individual's home or place of residence, including organizations that provide one or more of the following:

- Nursing care:
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; or
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.[22]

According to AHCA, the current definition of organization is problematic because it only refers to entities and does not include an individual person, which creates a loophole for an individual to employ health care personnel for the provision of home health services without having to obtain a license.[23]

Current law, requires an applicant for initial home health agency licensure to provide proof of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services. However, current law does include such requirements for a change of ownership or licensure renewal.[24]

Effect of the Bill

The bill amends the definition of home health agency by removing the reference to staffing services to clarify that a home health agency that provides only home health services, but not staffing services, is required to be licensed as a home health agency.

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[18] Supra FN 9.
[19] S. 400.462(12), F.S.
[20] Id.
[21] S. 400.462(22), F.S. Organization means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.
[22] S. 400.462(14), F.S.
[23] Supra FN 9.
[24] S. 400.471((2)(g), F.S.

The bill also deletes the definition of organization to exclude programs that offer home visits for a single profession. According to AHCA, this change will clarify that current law only requires a home health license when an organization offers multiple professional disciplines in the home.[25] The bill amends various sections of home health agency statute to replace the term "organization" with "person or entity.

The bill retains an exemption from home health agency licensure for a person or entity that provides skilled care by health care professionals licensed solely under part I of ch. 464, F.S. (nursing), part I, part III, or part V of ch. 408, F.S. (speech, operational or respiratory therapy), or ch. 486, F.S. (physical therapy). According to AHCA, this exemption indirectly exists within the current definition of "organization", which is deleted by the bill.[26] AHCA states that by adding this exemption, a person or entity would be able to voluntarily apply for a certificate of exemption from home health agency licensure as documentation of exempt status.[27]

The bill requires applicants for, not only initial licensure, but also for a change of ownership or license renewal to provide proof to AHCA of accreditation and a survey demonstrating compliance with survey standards prior to the addition of skilled care or services.

Health Care Clinic Act

The Health Care Clinic Act (Act), ss. 400.990 – 400.995, F.S., was enacted in 2003 to reduce fraud and abuse in the personal injury protection (PIP) insurance system.[28] Pursuant to the Act, AHCA licenses health care clinics, ensures that clinics meet basic business and billing related standards, and provides administrative oversight.

Pursuant to the uniform licensure requirements of part II of ch. 408, F.S., applicants for licensure as a health care clinic are required to demonstrate financial ability to operate by showing that the applicant's assets, credits, and projected revenues will meet or exceed projected liabilities and expense[29] As an alternative to submitting proof of financial ability to operate, s. 400.991, F.S., allows a health care clinic to submit a surety bond to AHCA of at least $500,000. According to AHCA, no clinic has ever submitted a surety bond instead of submitting proof of financial ability to operate.[30] The bill amends s. 400.991, F.S., to remove the alternative option for a health care clinic to prove their financial ability to operate.

Healthcare Clinic Exemptions

Federally Certified Providers

Current Situation

Any entity that meets the definition of a health care clinic must be licensed as a health care clinic. Although all clinics must be licensed by AHCA, the Act creates many exceptions from the health care clinic licensure requirements.[31] A health care clinic may voluntarily apply for a certificate of exemption for a fee of $100.[32] Certificates of exemption are valid for up to two years.[33] Among many other exemptions, certain federally certified entities are exempt from licensure under the Act, including:

[25] Supra FN 9
[26] Id.
[27] Id.
[28] Chapter 2003-411, Laws of Fla. PIP insurance is no fault auto insurance that provides certain benefits for individuals injured as a result of a motor vehicle accident. All motor vehicles registered in this state must have PIP insurance.
[29] S. 408.8065, F.S., and s. 408.810, F.S.
[30] Supra FN 9.
[31] S. 400.9905(4), F.S.
[32] S. 400.9935(6), F.S.
[33] Id.

- Entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that own, directly or indirectly, entities federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories;
- Entities that are owned, directly or indirectly, by an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories; and
- Entities that are under common ownership, directly or indirectly, with an entity federally certified as end-stage renal disease providers, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech-language pathology providers, and clinical laboratories.

Federal certification requirements are more stringent than the licensure standards of the Health Care Clinic Act. Current law does not include exemptions from health care clinic licensure for federally certified community mental health center-partial hospitalization programs[34], portable x-ray providers[35], or rural health care clinics[36].

Effect of the Bill

The bill creates exemptions for these providers similar to current exemptions for other federally certified providers. Approximately 200 providers will qualify for this exemption.[37]

Entities Owned by a Mutual Insurance Holding Company

Current Situation

In 2019, SB 2502 (Implementing the 2019-2020 GAA), provided two exemptions from health care clinic licensure in order to implement specific appropriations 208[38], 225-236, and 368[39] of the GAA. The exemptions expire on July 1, 2020. Specifically, the bill provided an exemption for entities that are:

- Under the common ownership or control by a mutual insurance holding company with an entity licensed or certified under chapter 624, F.S., or chapter 641, F.S., that has $1 billion or more in total annual sales in this state; or
- Owned by an entity who is a behavioral health service provider in at least 5 states other than Florida and that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services and where one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state and who is responsible for supervising the business activities of the entity and is responsible for the entity's compliance with state law for purposes of part X of chapter 400, F.S.

Effect of the Bill

The bill creates permanent statutory exemptions for the exemptions above that are set to expire on July 1, 2020.

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[34] 42 C.F.R. §§. 485.900-485.920.
[35] 42 C.F.R. §§. 486.100-486.110.
[36] 42 C.F.R. §§. 491.1-491.12.
[37] Supra FN 9.
[38] 2019, HB 5001, General Appropriations Act, Funds in specific appropriation 208 are for the inclusion of freestanding dialysis clinics in the Medicaid Program.
[39] 2019, HB 5001, General Appropriations Act, Funds in specific appropriation 368 are to fund the following projects: Citrus Health Network; Apalachee Center Forensic Treatment Services; Mental Health Care-Forensic Treatment Services; Apalachee Center-Civil Treatment Services; New Horizons of the Treasure Coast-Civil Treatment Services.

Medicaid Providers

Current Situation

Applied Behavioral Analysis (ABA) is an umbrella term referring to the principles and techniques used to assess, treat, and prevent challenging behaviors while promoting new, desired behaviors. ABA focuses on improving social skills, communication, reading, and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence. ABA can be effective for children and adults with psychological disorders in a variety of settings, including schools, workplaces, homes, and clinics.[40]

In 2019, AHCA required all ABA provider groups to be licensed as health care clinics under ch. 400, F.S., as a condition of Medicaid enrollment, effective July 1, 2020. This change will also require ABA provider groups to employ a physician to be the medical or clinical director. Consequently, over 30,000 Medicaid providers will be required to obtain a health care clinic license or a certificate of exemption from licensure as a health care clinic by July 1, 2020.[41]

Effect of the Bill

The bill creates an exemption from health care clinic licensure for all Medicaid providers. AHCA estimates that approximately 28,291 ABA providers would qualify for the exemption.[42]

The bill also allows a clinic that exclusively provides behavior analysis services to appoint as a clinic director, a health care practitioner who maintains an active and unencumbered certification as a Board Certified Behavior Analyst.

Public Posting of a Schedule of Charges

Current Situation

Current law in s. 400.9935, F.S., requires health care clinics to publish a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for services by cash, check, credit card, or debit card. The schedule may group services by three price levels, listing services in each price level. The schedule may be a sign that must be at least 15 square feet in size or an electronic messaging board that is at least three square feet in size. A health care clinic that does not publish and post a schedule of charges may be assessed a fine of up to $1,000 per day.

Further, the statute requires the schedule to be posted in a conspicuous place in the reception area of an urgent care center. The specific reference to an urgent care center complicates the interpretation as to whether the posting requirements apply only to urgent care centers or to all health care clinics. As a result, AHCA only has the authority to enforce the posting requirements on urgent care centers.

Effect of the Bill

The bill removes the ambiguity of the current law by specifically requiring an urgent care center to post a schedule of charges in the in their reception area. The bill is silent as to the means by which all other health care clinics will be required to publish a schedule of charges; however, AHCA has indicated that the Agency will require clinics to publish them on the clinic's website, in a document available at the

[40] "Applied Behavioral Analysis", *Psychology Today*, available at https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis (last accessed January 31, 2020).
[41] Supra FN 9.
[42] Id.

clinic, in a scanned document that can be emailed upon request, or in posted signage of an undetermined size.[43]

Legislatively Mandated Reports

Hospice Annual Report

Current Situation

Section 400.60501, F.S., provides reporting requirements for AHCA on certain hospice data. AHCA is required to make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices. Further, AHCA is required to develop an annual report that analyzes and evaluates the national hospice outcome measures and survey data.

Effect of the Bill

The bill removes the requirement for AHCA to develop an annual report, but retains the requirement for AHCA to make the national hospice outcome measures and survey data available to the public. AHCA already publishes the outcome measures and survey data on FloridaHealthFinder.gov.[44]

Electronic Prescribing Annual Report

Current Situation

Electronic prescribing is the electronic review of a patient's medication history, the electronic generation of the patient's prescription, and the electronic transmission of the patient's prescription to a pharmacy.[45] Current law requires AHCA to work with electronic prescribing initiatives and relevant stakeholders to create a clearinghouse of information on electronic prescribing for health care practitioners, health care facilities, and pharmacies.[46] AHCA must monitor the implementation of electronic prescribing and provide an annual report on the progress of implementation to the Governor and the Legislature. The report is also required to include information on federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically submitted.[47] AHCA publishes the electronic prescribing data online[48], and it is updated quarterly.

Effect of the Bill

The bill removes the requirement for AHCA to provide an annual report on the progress of implementation to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish the report online.

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[43] Supra FN 9.
[44] AHCA, FloridaHealthFinder.gov, Hospice Quality Reporting Program, CAHPS (Patient and Family Experience Measures-Consumer Assessment of Healthcare Providers and Systems), and HIS (Quality of Patient Care Measures-Hospice Item Set), available at https://www.floridahealthfinder.gov/Hospice/Hospice.aspx (last accessed January 31, 2020).
[45] S. 408.0611(2)(a), F.S.
[46] Ch. 2007-156, Laws of Fla.
[47] S. 408.0611(4), F.S.
[48] AHCA, ePrescribing Dashboard, Quarterly Metrics Summary and Data Charts, available at http://fhin.net/eprescribing/dashboard/index.shtml (last accessed January 31, 2020).

Emergency Department Utilization Annual Report

Current Situation

Section 408.062, F.S., requires AHCA to conduct research, analyses, and studies relating to health care costs and access to and quality of health care services, which must include the use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing non-urgent care in emergency departments. Based on this monitoring and assessment, AHCA must submit an annual report to the Governor and the Legislature, and substantive Legislative committees. Most of, but not all, of the information required to be in the annual report is available anytime by using the emergency department query tool on FloridaHealthFinder.gov. Not included on the website is the use of emergency department services by patient acuity level and its impact on increasing hospital cost by providing non-urgent care in emergency departments.

Effect of the Bill

The bill repeals annual report on emergency department utilization required to be sent to the Governor and the Legislature. Instead, the bill requires AHCA to annually publish online, information on the use of emergency department services by patient acuity level.

Florida Center for Health Information and Transparency Annual Report

Current Situation

Section 408.062, F.S., requires AHCA to publish on its website, and make available in a hard copy format upon request, data on patient charges, volumes, length of stay, and performance indicators from data collected from hospitals, for specific procedures, medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities. The data must be updated quarterly. AHCA is also required to submit an annual report on the status of the collection of data and publication of health care quality measures to the Governor and the Legislature, and substantive Legislative committees. All of this information is easily accessible on FloridaHealthFinder.gov[49], and the data is updated bi-weekly.

Effect of the Bill

The bill retains the requirement for AHCA to publish data currently contained in the annual report, but removes the requirement for the annual report to be submitted to the Governor, and the Legislature. According to AHCA, if the bill passes, all of the data that is currently required to be published will still be easily accessible for consumers and others.[50]

State Health Expenditures Annual Report

Current Situation

Section 408.063, F.S., requires AHCA to annually publish a comprehensive report of state health expenditures, which must identify the contribution of health care dollars made by all payers, and the dollars expended by type of health care service. According to AHCA, the data used to generate the Expenditure Report is not available until several years after the reporting period. AHCA publishes the current year report utilizing the available data from three years prior. The report includes information collected from the Department of Economic Opportunity, the U.S. Census Bureau, CMS, the Florida Office of Insurance Regulation (OIR), and the U.S. Bureau of Economic Analysis. All data is publicly

[49] AHCA, Research Studies and Reports, Florida Center for Health Information and Transparency Annual Report, available at https://www.floridahealthfinder.gov/researchers/studies-reports.aspx (last accessed January 31, 2020).
[50] Supra FN 9

available on relevant government agency websites. The dashboard associated with this report received only 14 website hits over the course of a year.[51]

Effect of the Bill

The bill removes the requirement for AHCA to publish the State Health Expenditures Annual Report. Should the bill pass, AHCA will no longer collect this information or publish it in any manner.

Health Flex Plan Annual Report

Current Situation

The health flex plan began as a pilot program[52] to cover basic and preventative health care services to low-income families not eligible for public assistance programs and not covered by private insurance. Health flex plans are unique compared to the common health insurance plan. A health flex plan may limit or exclude benefits otherwise required by law, or they can cap the total amount of claims paid per year to an enrollee.[53] The pilot program began with three health flex plans in the three areas of the state with the highest number of uninsured individuals. Today, there is only one remaining health flex plan with less than 300 members.[54]

Section 408.909(9), F.S., requires AHCA and OIR to jointly submit an annual report to the Governor and the Legislature, which must include:

- An evaluation of the entities that seek approval as health flex plans;
- The number of enrollees and the scope of health care coverage offered;
- An assessment of the health flex plans and their potential applicability in other settings; and
- Information to evaluate low-income consumer driven benefit packages

According to AHCA, the online report has received no website hits in over a year.[55]

Effect of the Bill

The bill repeals the health flex plan evaluation and annual reporting requirements. Should the bill pass, AHCA and OIR will still be required to collect certain data on health flex plans.

Cover Florida Health Care Access Program Annual Report

Current Situation

In 2008, the Legislature created the Cover Florida Health Access Program to provide affordable health care options for uninsured residents. A Cover Florida plan must have two alternate benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage. Plans without catastrophic coverage must provide coverage options for certain services like preventive health services, behavioral health services, durable medical equipment, inpatient hospital stays, hospital emergency services, urgent care and more.[56]

[51] Id.
[52] Ch. 2002-389, Laws of Fla.
[53] S. 409.909(3), F.S.
[54] Supra FN 9.
[55] Id.
[56] S. 408.9091(4)(a), F.S.

Section 408.9091, F.S., requires AHCA and OIR to:

- Evaluate the Program and its effect on the entities that seek approval, the number of enrollees, and on the scope of the health care coverage offered;
- Provide an assessment of the plans and their potential applicability in other settings;
- Use plans to gather more information to evaluate low-income, consumer-driven benefit packages; and
- Jointly submit an annual report to the Governor and the Legislature, which must include the gathered information above, and must include recommendations relating to the successful implementation and administration of the program.

Currently, there are no plans participating in the Cover Florida Health Care Access Program, and the last participating plan terminated its coverage policies in 2015.[57]

Effect of the Bill

The bill removes the requirement for AHCA and OIR to submit an annual report on the Cover Florida Health Care Access Program to the Governor and the Legislature. The bill retains current law requiring AHCA and OIR to evaluate and assess the program.

ALF Sanctions Annual Report

Current Situation

Section 429.19(9), F.S., requires AHCA to annually develop a list of all facilities that were sanctioned or fined, which must include the number and class of violations involved, the penalties imposed, and the current status of the cases. Upon developing the list, AHCA must annually disseminate it to the Department of Elder Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families must then disseminate the list to their contracted service providers who are responsible for referring individuals to an ALF for residency. The list may be provided electronically or through AHCA's website. The statutory requirement for AHCA to annually disseminate the list of ALF sanctions was adopted in 1993. Since that time, AHCA has committed significant resources towards moving information online that may be used by a consumer in selecting a health care provider, including the history of an ALF's citations and violations. The provider specific information on FloridaHealthFinder.gov is updated nightly to reflect licensure status, inspection details, and legal case activities.[58] However, aggregate data on the ALF industry is not provided on the website.

Effect of the Bill

The bill repeals s. 419.19(9), F.S. As a result, AHCA would no longer be required to annually compile or disseminate a list on facilities that were sanctioned or fined. Information on sanctions and fines is available online by specific provider.[59] Further, DCF would no longer be required to disseminate the list to their contracted service providers.

[57] Supra FN 9.
[58] Id.
[59] AHCA, FloridaHealthFinder.gov, ALF compare, available at https://www.floridahealthfinder.gov/CompareSC/SCSelectFilters.aspx (last accessed January 31, 2020).

Background Screening

Current Situation

In 2012, the Legislature created the Care Provider Background Screening Clearinghouse (Clearinghouse) to create a single "program" of screening individuals and allow for the results of criminal history checks of persons acting as covered care providers to be shared among the specified agencies.[60] Designated agencies include AHCA, the Department of Health, the Department of Children and Families, the Department of Elder Affairs, the Agency for Persons with Disabilities, Vocational Rehabilitation within the Department of Education, and the Department of Juvenile Justice.

Section 408.809(2), F.S., allows providers to provide proof of screening from agencies joining the Clearinghouse to meet screening requirements until such time until such time as the specified agency is fully implemented in the Clearinghouse. Final implementation of the Clearinghouse by the designated state agencies was required by October 1, 2013.

The Clearinghouse was initially implemented by AHCA on January 1, 2013. It included language that allowed a person currently employed as of June 30, 2014, who was screened and qualified prior to employment, to apply for an exemption in the event that a disqualifying offense, that the employee committed prior to screening, is later added to the law. Because statute still includes the date of June 30, 2014, the exemption is unenforceable.

Section 408.809(5), F.S., provides a background screening schedule for a controlling interest, employee, or individual under contract with a licensee. The background screening schedule is expired.

Section 409.907, F.S., provides background screening requirements for Medicaid providers. According to AHCA, the background screening requirements are only intended to apply to staff having direct access to patients, but some Medicaid managed care plans have been screening all staff beyond those with access to clients.[61]

Effect of the Bill

The bill allows an employee, who has previously qualified with background screening requirements, to apply for an exemption if the law is changed to add a disqualifying offense for which the employee committed prior to being screened.

The bill amends s. 408.809(2), F.S., to delete expired provisions relating implementation of the Clearinghouse. All specified agencies are now fully implemented in the Clearinghouse.

The bill also amends s. 408.809(5), F.S., to delete an expired background screening schedule.

The bill amends s. 409.907, F.S., clarify that background screening requirements for Medicaid providers apply to individuals who will have direct access to Medicaid recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient, or who supervises the delivery of goods or services to a Medicaid recipient.

Multiphasic Health Testing Centers

Current Situation

Multiphasic health testing centers are regulated by AHCA under part I of ch. 483, F.S. A multiphasic health testing center is a facility where specimens are taken from the human body for delivery to

[60] Ch. 2014-84, Laws of Fla.
[61] Supra FN 9.

registered clinical laboratories for analysis and certain measurements and tests are taken, such as height and weight, blood pressure, limited audio and visual, and electrocardiograms.[62]

The federal Clinical Laboratory Improvement Amendments Act (CLIA) requires a clinical laboratory to receive CLIA certification if it examines materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, a human being. The federal Centers for Medicare & Medicaid Services (CMS), within the United States Department of Health and Human Services, regulates all laboratory testing performed on humans in the United States through the CLIA.[63] The purpose of the CLIA program is to establish quality standards for all laboratory testing to ensure accuracy, reliability, and timeliness of test results regardless of where the test was performed.[64] The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality in CMS has the responsibility for implementing the CLIA Program, including laboratory registration, fee collection, onsite inspections, and enforcement.[65] In addition to CLIA inspections, AHCA is required to conduct biennial inspections of all licensed multiphasic health testing centers.

As of January 21, 2020, there were 187 multiphasic health testing centers licensed in Florida. Of these, 180 are CLIA certified, which means they are subject to federal inspections by CMS. The other 7 centers, although currently licensed, are not required to be licensed because they are not providing services that necessitate licensure as a multiphasic health testing center.[66]

Since 2011, AHCA has imposed only six fines against multiphasic health testing centers, and received only 10 complaints, with none substantiated.[67]

Effect of the Bill

The bill repeals licensure of multiphasic health testing centers. Currently, 180 licensed centers are CLIA certified and will continue to be regulated and inspected by federal CMS.

Provisional Licensure

Current Situation

Section 408.808, F.S., provides the uniform licensing requirements for all health care facilities regulated by AHCA. There are three types of licenses issued by AHCA, including, standard, inactive, and provisional licenses. A standard license is valid for two years and is issued to an applicant at the time of initial licensure, licensure renewal, or a change of ownership.[68] An inactive license is issued to a health care provider subject to CON review when the provider is licensed, but does not have a provisional license, and will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.[69]

A provisional license is issued to an applicant for licensure renewal when a proceeding is pending to deny or revoke their license.[70] A provisional license may also be issued to an applicant applying for a

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[62] S. 483.288(2), F.S.
[63] Centers for Medicare & Medicaid Services, *Clinical Laboratory Improvement Amendments (CLIA)*, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/CLIA/10_Categorization_of_Tests.asp (last accessed January 31, 2020).
[64] Department of Health and Human Services, Office of the Inspector General, *Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program*, (Aug. 2001), available at https://oig.hhs.gov/oei/reports/oei-05-00-00251.pdf (last accessed January 31, 2020)
[65] Id.
[66] Supra FN 9.
[67] Id.
[68] S. 408.808(1), F.S.
[69] S. 408.808(3), F.S.
[70] S. 408.808(2), F.S.

change of ownership. Provisional licensure must be limited to a specific period of time, up to 12 months, as determined by AHCA. ALF statutes allow AHCA to issue a provisional license to an applicant for initial licensure for a specific period of time not to exceed 6 months. Current law does not allow the issuance of a provisional license for initial licensure for any facility regulated by AHCA.

Effect of the Bill

The bill amends s. 408.808, F.S., to allow AHCA to issue a provisional license for initial licensure to all regulated providers. According to AHCA, there have been instances when a provider's license is revoked because they forgot to renew their license, so they have to go through the process of applying for initial licensure, which can often take a long time.[71] In such instances, residents or patients have to be moved and other accommodations must be made. Allowing AHCA to issue a provisional license in such instances will allow the provider to go through the licensure process while avoiding an interruption in client services.

Comprehensive Emergency Management Plans

Current Situation

Different provider types are subject to different comprehensive emergency management plan submission requirements in their authorizing statutes. ALFs are required to get plan approval by local emergency management officials prior to being licensed.[72] According to AHCA, some local jurisdictions refuse to review a plan until the provider is licensed, making it impossible for providers within those jurisdictions to become lawfully licensed.[73]

Effect of the Bill

The bill amends s. 408.821, F.S., to require providers that are required by authorizing statutes and AHCA rule to have a comprehensive emergency management plan to:

- Submit the plan within 90 days after initial licensure and change of ownership, and notify AHCA within 30 days after submission of the plan;
- Submit the plan annually and within 30 days after any significant modification to a previously approved plan;
- Respond with necessary plan revisions within 30 days after notification that plan revisions are required; and
- Notify AHCA within 30 days after approval of its plan by the local emergency management agency, county health department, or DOH.

Medicaid Program Integrity Hospital Retrospective Review Program

Current Situation

Section 409.905(5), F.S., requires AHCA to pay for all covered services for the medical care of a Medicaid recipient who is admitted to a hospital as an inpatient by a licensed physician or dentist. However, AHCA may limit the payment for inpatient hospital services, for a Medicaid recipient 21 years of age or older, to 45 days or the number of days necessary to comply with the General Appropriations Act (GAA). This statute authorizes AHCA to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the GAA, including:

- Prior authorization for inpatient psychiatric days;

[71] Supra FN 9.
[72] S. 429.41(1)(b), F.S.
[73] Supra FN 9.

- Prior authorization for non-emergency hospital inpatient admissions for individuals at least 21 years of age;
- Authorization of emergency and urgent-care admissions within 24 hours after admission;
- Enhanced utilization and concurrent review programs for highly utilized services;
- Reduction or elimination of covered days of service;
- Adjusting reimbursement ceilings for variable costs;
- Adjusting reimbursement ceilings for fixed and property costs; and
- Implementing target rates of increase.

Pursuant to s. 409.905(5)(a), F.S., AHCA must discontinue its hospital retrospective review program once it has implemented its prior authorization program for hospital inpatient services.

AHCA's Bureau of Medicaid Program Integrity (MPI) performs routine pre-claim and post-claim reviews to determine the appropriateness of historical, existing, and future provider reimbursement. Since the inception of MPI, AHCA's claim review processes have recovered in excess of one billion dollars.[74]

MPI also conducts provider audits based on probable cause through the Alien Audit Program, which was created in 2010[75]. The Alien Audit Program was developed after an audit report from the Health and Human Services Office of Inspector General directed the state to return the federal share of erroneous payment for certain hospital claims related to Emergent Medicaid. Since its inception, the Alien Audit Program has closed 668 cases and collected $57,056,455.79.

In February, 2019, the First District Court of Appeal ruled that s. 409.9905(5)(a), F.S., precludes post-payment audits, including the Alien Audit Program audits, to determine the appropriateness of reimbursement, including whether prior authorization was obtained under false pretenses.[76] As a result, AHCA lost $13,449,595.12 related to 42 cases that have been or will be closed at zero overpayment due to the court ruling.[77]

Federal regulations require AHCA to have a post-payment review process for all Medicaid services.[78] State plans are also required, pursuant to Federal regulations, to have processes relating to identification, investigation, and referral of suspected fraud and abuse cases, which includes the requirement to have a post-payment review process.[79]

Effect of the Bill

According to AHCA, the directive in s. 409.905(5)(a), F.S., to discontinue an inpatient retrospective review program was intended to refer to a specific program conducted in the Division of Medicaid when the Division shifted to a prior authorization review.[80] The bill removes obsolete language and adds language to clarify that AHCA may conduct reviews to determine fraud, abuse and overpayment in the Medicaid program. As a result, MPI would be able continue conducting retrospective reviews of hospital claims.

Medicaid Program Integrity Legal Fees

Current Situation

Current law authorizes AHCA to recover legal costs if they prevail in an overpayment case, but does not specifically reference costs for outside legal counsel. However, in 2019, the Division of

[74] Id.
[75] Ch. 2009-223 Laws of Fla.
[76] *Lee Mem'l Health Sys. Gulf Coast Med. Ctr. v. State of Fla., Agency for Health Care Admin.*, 272 So.3d 431 (Fla. 1st DCA 2019).
[77] Supra FN 9.
[78] 42 C.F.R. § 456.23.
[79] 42 C.F.R. § 455.12.
[80] Supra FN 9.

Administrative Hearings (DOAH) ruled that s. 409.913(23)(a), F.S., does not authorize AHCA to recover full attorney's fees on MPI legal cases involving outside counsel.[81]

Effect of the Bill

The bill amends s. 409.913(23)(a), F.S., to provide legal authority for AHCA to collect all legal fees incurred while defending a case if AHCA prevails, including the cost of outside counsel.

The bill provides an effective date of July 1, 2020.

Statewide Medicaid Managed Care Plan

Current Situation

Section 409.967, F.S., requires AHCA to establish a 5-year contract with each managed care plan selected during the procurement process.

Section 409.973, F.S., requires AHCA to establish 5-year contracts with managed care plans in the prepaid dental health program during the procurement process.

Effect of the Bill

The bill requires AHCA to re-procure contracts with managed care plans in the Statewide Medicaid Managed Care program and the prepaid dental health program every 6 years instead of every 5 years, beginning with the contract procurement process initiated during the 2023 calendar year. The bill requires AHCA to extend the term of existing plan contracts for the prepaid dental health program until December 31, 2024.

Except as otherwise expressly provided in this act and except for section 46, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 383.327, F.S., relating to birth and death records; reports.
Section 2: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 3: Repeals s. 395.7015, F.S., relating to annual assessment on health care entities.
Section 4: Amends s. 395.7016, F.S., relating to annual appropriation.
Section 5: Amends s. 400.19, F.S., relating to right of entry and inspection.
Section 6: Amends s. 400.462, F.S., relating to definitions.
Section 7: Amends s. 400.464, F.S. relating to home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.
Section 8: Amends s. 400.471, F.S., relating to application for license; fee.
Section 9: Amends s. 400.492, F.S., relating to provision of services during an emergency.
Section 10: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; penalties.
Section 11: Amends s. 400.509, F.S., relating to registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.
Section 12: Amends s. 400.605, F.S., relating to administration; forms; fees; rules; inspections; fines.
Section 13: Amends s. 400.60501, F.S., relating to outcome measures; adoption of federal quality measures; public reporting.
Section 14: Amends s. 400.9905, F.S., relating to definitions.

[81] State of Florida, Division of Administrative Hearings, Case No. 18-5986F, June 12, 2019, the case had an overpayment of $637,973.10 and a sanction of $127,594.62 and AHCA was seeking fees and costs of $330,186.14, but DOAH ruled that AHCA has the ability to collect the "costs" but not the "fees".

Section 15: Amends s. 400.991, F.S., relating to licensure requirements; background screenings; prohibitions.
Section 16: Amends s. 400.9935, F.S., relating to clinic responsibilities.
Section 17: Amends s. 408.033, F.S., relating to local and state health planning.
Section 18: Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
Section 19: Amends s. 408.0611, F.S., relating to electronic prescribing clearinghouse.
Section 20: Amends s. 408.062, F.S., relating to research, analyses, studies, and reports.
Section 21: Amends s. 408.063, F.S., relating to dissemination of health care information.
Section 22: Amends s. 408.802, F.S., relating to applicability.
Section 23: Amends s. 408.803, F.S., relating to definitions.
Section 24: Amends s. 408.806, F.S., relating to license application process.
Section 25: Amends s. 408.808, F.S., relating to license categories.
Section 26: Amends s. 408.809, F.S., relating to background screening; prohibited offenses.
Section 27: Amends s. 408.811, F.S., relating to right of inspection; copies; inspection reports; plan for correction of deficiencies.
Section 28: Amends s. 408.820, F.S., relating to exemptions.
Section 29: Amends s. 408.821, F.S., relating to emergency management planning; emergency operations; inactive license.
Section 30: Amends s. 408.831, F.S., relating to denial, suspension, or revocation of a license, registration, certificate, or application.
Section 31: Amends s. 408.832, F.S., relating to conflicts.
Section 32: Amends s. 408.909, F.S., relating to health flex plans.
Section 33: Amends s. 408.9091, F.S., relating to Cover Florida Health Care Access Program.
Section 34: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 35: It is the intent of the Legislature that s. 409.905(5)(a), F.S., as amended by this act, confirm and clarify existing law.
Section 36: Amend s. 409.907, F.S., relating to Medicaid provider agreements.
Section 37: Amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program.
Section 38: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 39: Amends s. 409.973, F.S., relating to provision of dental services.
Section 40: Amends s. 429.11, F.S., relating to initial application for license; provisional license.
Section 41: Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.
Section 42: Amends s. 429.35, F.S., relating to maintenance of records; reports.
Section 43: Amends s. 429.905, F.S., relating to exemptions; monitoring of adult day care center programs collocated with assisted living facilities or licensed nursing home facilities.
Section 44: Amends s. 429.929, F.S., relating to rules establishing standards.
Section 45: Repeals part I of chapter 483, F.S., relating to multiphasic health testing centers.
Section 46: Provides an effective date of July 1, 2020, except as otherwise expressly provided in this act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   (See fiscal comments)

2. Expenditures:

   (See fiscal comments)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill repeals licensure for multiphasic health testing center. Currently there are 187 licensed multiphasic health testing centers. As a result, multiphasic health testing centers will no longer be required to pay the biennial license renewal fee of $952.64.

The bill exempts from health care clinic licensure, community mental health partial-hospitalization programs, and portable x-ray providers, and rural health care clinics. These providers will no longer be required to pay the $2,000 biennial license renewal fee. AHCA estimates that approximately 200 providers would qualify for the exemption.

The bill also exempts Medicaid providers, including behavior analysis providers, from health care clinic licensure. These providers are not currently required to be licensed, but licensure will be required effective July 1, 2020[82]. AHCA expects 28,291 providers to qualify for the exemption. Providers who qualify for the exemption would not have to pay the $2,000 initial licensure fee.

D. FISCAL COMMENTS:

If the bill becomes law, AHCA would experience a loss in annual revenue of $489,071.84 and a commensurate workload reduction, resulting from the repeal of multiphasic health testing center licensure ($89,071.84), and the new exemptions from health care clinic licensure for community mental health partial-hospitalization programs, portable x-ray providers, and rural health care clinics ($400,000).

Exempting low-risk Medicaid providers from health care clinic licensure will result in a cost avoidance to AHCA. AHCA previously asked for 13 full-time equivalent positions in a legislative budget request to process the approximately 28,000 anticipated applications that will be submitted by July 1, 2020.[83]

AHCA lost approximately $13.5 million in revenue related to 42 cases that have been or will be closed at zero overpayment due to the court ruling on retrospective hospital audits.[84] The MPI retrospective alien audit case was an isolated example, however, the bill could protect AHCA from not being able to recoup significant amounts of revenue in the future.

The bill provides authority for AHCA to collect all legal fees incurred while defending a Medicaid Program integrity case if AHCA prevails, including the cost of outside counsel. AHCA's tracking system for Medicaid recovery amounts does not distinguish legal fees, so they are unable to determine the future impact of the proposed change; however, AHCA has incurred over $300,000 in legal fees for a single case.

The net fiscal impact is indeterminate. However, the fiscal impact is expected to be minimal because any loss in revenue will likely be offset by gains in savings and workload reductions. Specifically, the

[82] Florida Medicaid, Provider Enrollment Policy, at pg. 86, available at https://ahca.myflorida.com/medicaid/review/Rules_in_Process/Proposed/59G-1.060_Enrollment_ProposedRule.pdf (last accessed January 31, 2020).
[83] Supra FN 9.
[84] Id.

loss of revenue from licensure repeals and exemptions coupled with the potential saving in funds recouped from Medicaid overpayments and attorney fees.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making to AHCA to implement the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Health Market Reform Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Restructures fines for nursing homes that requires additional inspections due to poor performance;
- Redefines "home health agency" to eliminate a requirement to provide staffing services;
- Replaces "organization" with "entity or person" throughout the home health agency act;
- Retains definition of chief financial officer in the Health Care Clinic Act;
- Defines the "low-risk provider" for purposes inspection waivers or delays under the bill;
- Removes outdated language and dates from background screening statutes;
- Provides legislative intent that bill language related to retrospective reviews of Medicaid hospital billing confirm and clarify existing law; and
- Expands background screening requirements for Medicaid providers; requires screening for any person with direct access to recipient financial, medical or service records.

The analysis is drafted to the committee substitute as passed by the health market reform subcommittee.

A bill to be entitled

An act relating to the Agency for Health Care Administration; amending s. 383.327, F.S.; requiring birth centers to report certain deaths and stillbirths to the Agency for Health Care Administration; removing a requirement that a certain report be submitted annually to the agency; authorizing the agency to prescribe by rule the frequency at which such report is submitted; amending s. 395.003, F.S.; removing a requirement that specified information be listed on licenses for certain facilities; repealing s. 395.7015, F.S., relating to an annual assessment on health care entities; amending s. 395.7016, F.S.; conforming a provision to changes made by the act; amending s. 400.19, F.S.; revising provisions requiring the agency to conduct licensure inspections of nursing homes; requiring the agency to conduct additional licensure surveys under certain circumstances; revising a provision requiring the agency to assess a specified fine for such surveys; amending s. 400.462, F.S.; revising definitions; amending ss. 400.464, 400.471, 400.492, 400.506, and 400.509, F.S.; revising provisions relating to licensure requirements for home health agencies to conform to changes made by the act; exempting certain

persons and entities from such licensure requirements; amending s. 400.605, F.S.; removing a requirement that the agency conduct specified inspections of certain licensees; amending s. 400.60501, F.S.; removing an obsolete date and a requirement that the agency develop a specified annual report; amending s. 400.9905, F.S.; revising the definition of the term "clinic"; amending s. 400.991, F.S.; conforming provisions to changes made by the act; removing the option for health care clinics to file a surety bond under certain circumstances; amending s. 400.9935, F.S.; requiring certain clinics to publish and post a schedule of charges; amending s. 408.033, F.S.; conforming a provision to changes made by the act; amending s. 408.061, F.S.; revising provisions requiring health care facilities to submit specified data to the agency; amending s. 408.0611, F.S.; requiring the agency to annually publish a report on the progress of implementation of electronic prescribing on its Internet website; amending s. 408.062, F.S.; requiring the agency to annually publish certain information on its Internet website; removing a requirement that the agency submit certain annual reports to the Governor and Legislature; amending s. 408.063, F.S.; removing a requirement that

the agency annually publish certain reports; amending ss. 408.802, 408.820, 408.831, and 408.832, F.S.; conforming provisions to changes made by the act; amending s. 408.803, F.S.; conforming a provision to changes made by the act; providing a definition of the term "low-risk provider"; amending s. 408.806, F.S.; exempting certain low-risk providers from a specified inspection; amending s. 408.808, F.S.; authorizing the issuance of a provisional license to certain applicants; amending s. 408.809, F.S.; revising provisions relating to background screening requirements for certain licensure applicants; removing an obsolete date and provisions relating to certain rescreening requirements; amending s. 408.811, F.S.; authorizing the agency to exempt certain low-risk providers from inspections and conduct unannounced licensure inspections of such providers under certain circumstances; authorizing the agency to adopt rules to waive routine inspections and grant extended time periods between relicensure inspections under certain conditions; amending s. 408.821, F.S.; revising provisions requiring licensees to have a specified plan; providing requirements for the submission of such plan; amending s. 408.909, F.S.; removing a requirement that the agency and Office of

Insurance Regulation evaluate a specified program; amending s. 408.9091, F.S.; removing a requirement that the agency and office jointly submit a specified annual report to the Governor and Legislature; amending s. 409.905, F.S.; providing construction for a provision that requires the agency to discontinue its hospital retrospective review program under certain circumstances; providing legislative intent; amending s. 409.907, F.S.; requiring that a specified background screening be conducted through the agency on certain persons and entities; amending s. 409.913, F.S.; revising a requirement that the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs submit a specified report to the Legislature; authorizing the agency to recover specified costs associated with an audit, investigation, or enforcement action relating to provider fraud under the Medicaid program; amending ss. 409.967 and 409.973, F.S.; revising the length of managed care plan and Medicaid prepaid dental health program contracts, respectively, procured by the agency beginning during a specified timeframe; requiring the agency to extend the term of certain existing contracts until a specified date; amending s. 429.11, F.S.; removing an authorization for the issuance of a

provisional license to certain facilities; amending s. 429.19, F.S.; removing requirements that the agency develop and disseminate a specified list and the Department of Children and Families disseminate such list to certain providers; amending ss. 429.35, 429.905, and 429.929, F.S.; revising provisions requiring a biennial inspection cycle for specified facilities and centers, respectively; repealing part I of chapter 483, F.S., relating to The Florida Multiphasic Health Testing Center Law; providing effective dates.

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

Section 1. Subsections (2) and (4) of section 383.327, Florida Statutes, are amended to read:

383.327 Birth and death records; reports.—

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner and the agency.

(4) A report shall be submitted ~~annually~~ to the agency. The contents of the report and the frequency at which it is submitted shall be prescribed by rule of the agency.

Section 2. Subsection (4) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty bed need methodology shall be specified as general beds.~~ A licensed facility shall not operate a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

Section 3. Section 395.7015, Florida Statutes, is repealed.

Section 4. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015,~~ ~~and~~ the reduction by chapter 2000-256, Laws of Florida, in the assessment on hospitals under s. 395.701~~,~~ and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701~~,~~ as state match for the state's Medicaid program.

Section 5. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall conduct periodic, ~~every 15 months conduct at least one~~ unannounced licensure inspections ~~inspection~~ to determine compliance by the licensee with statutes, and with rules adopted ~~promulgated~~ under ~~the provisions of~~ those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If the facility has been cited for a class I deficiency or~~,~~ has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, the agency shall conduct an additional licensure survey ~~or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency~~. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the additional licensure survey ~~6-month survey cycle~~. The fine for the additional licensure survey ~~2-year period~~ shall be $3,000 ~~$6,000, one-half to be paid at the completion of each survey~~. The agency may adjust such ~~this~~ fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through

subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to ~~the provisions of~~ chapter 110.

Section 6. Subsections (23) through (30) of section 400.462, Florida Statutes, are renumbered as subsections (22) through (29), respectively, and subsections (12), (14), (17), and (21) and present subsection (22) of that section are amended to read:

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

(12) "Home health agency" means a person or entity ~~an organization~~ that provides one or more home health services ~~and staffing services~~.

(14) "Home health services" means health and medical services and medical supplies furnished ~~by an organization~~ to an individual in the individual's home or place of residence. The term includes ~~organizations that provide one or more of~~ the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(17) "Home infusion therapy provider" means a person or entity ~~an organization~~ that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(21) "Nurse registry" means a ~~any~~ person or entity that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395, this chapter, or chapter 429 or other business entities.

~~(22) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline; a health care professional and a home health aide or certified nursing assistant; more than one home health aide; more than one certified nursing assistant; or a home health aide and a certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.~~

Section 7. Subsections (1), (4), and (5) of section 400.464, Florida Statutes, are amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and persons or entities licensed or registered by or applying for such licensure or registration from the Agency for Health Care Administration pursuant to this part. A license or registration issued by the agency is required in order to operate a home health agency in this state. A license or registration issued on or after July 1, 2018, must specify the home health services the licensee or registrant ~~organization~~ is authorized to perform and indicate whether such specified services are considered skilled care. The

provision or advertising of services that require licensure or registration pursuant to this part without such services being specified on the face of the license or registration issued on or after July 1, 2018, constitutes unlicensed activity as prohibited under s. 408.812.

(4)(a) A licensee or registrant ~~An organization~~ that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or registration number issued to the licensee or registrant ~~organization~~ by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant that ~~who~~ fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500. The holder of a license or registration issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license or registration other than the one it has been issued.

(b) The operation or maintenance of an unlicensed home health agency or the performance of any home health services in violation of this part is declared a nuisance, inimical to the public health, welfare, and safety. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such

violation, or to enjoin the future operation or maintenance of the home health agency or the provision of home health services in violation of this part or part II of chapter 408, until compliance with this part or the rules adopted under this part has been demonstrated to the satisfaction of the agency.

(c) A person or entity that ~~who~~ violates paragraph (a) is subject to an injunctive proceeding under s. 408.816. A violation of paragraph (a) or s. 408.812 is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(d) A person or entity that ~~who~~ violates ~~the provisions of~~ paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person or entity that ~~who~~ commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(e) A ~~Any~~ person or entity that ~~who~~ owns, operates, or maintains an unlicensed home health agency and ~~who~~, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

(f) A ~~Any~~ home health agency that fails to cease operation after agency notification may be fined in accordance with s. 408.812.

(5) The following are exempt from ~~the~~ licensure as a home health agency under ~~requirements of~~ this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons with developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding ~~the provisions of~~ this act.

5. The Department of Children and Families.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part I of chapter 429, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part IV of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family-care home services for which the adult family-care home is licensed under part II of chapter 429, to serve the residents in its facility.

(o) A person or entity that provides skilled care by health care professionals licensed solely under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486.

(p) A person or entity that provides services using only volunteers or individuals related by blood or marriage to the patient or client.

Section 8. Paragraph (g) of subsection (2) of section 400.471, Florida Statutes, is amended to read:

400.471 Application for license; fee.—

(2) In addition to the requirements of part II of chapter 408, the initial applicant, the applicant for a change of ownership, and the applicant for the addition of skilled care services must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(g) In the case of an application for initial licensure, an application for a change of ownership, or an application for the addition of skilled care services, documentation of accreditation, or an application for accreditation, from an accrediting organization that is recognized by the agency as having standards comparable to those required by this part and part II of chapter 408. A home health agency that does not provide skilled care is exempt from this paragraph. Notwithstanding s. 408.806, the ~~an initial~~ applicant must provide proof of accreditation that is not conditional or provisional and a survey demonstrating compliance with the requirements of this part, part II of chapter 408, and applicable rules from an accrediting organization that is

recognized by the agency as having standards comparable to those required by this part and part II of chapter 408 within 120 days after the date of the agency's receipt of the application for licensure. Such accreditation must be continuously maintained by the home health agency to maintain licensure. The agency shall accept, in lieu of its own periodic licensure survey, the submission of the survey of an accrediting organization that is recognized by the agency if the accreditation of the licensed home health agency is not provisional and if the licensed home health agency authorizes release of, and the agency receives the report of, the accrediting organization.

Section 9. Section 400.492, Florida Statutes, is amended to read:

400.492 Provision of services during an emergency.—Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation. The plan shall

describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other health care providers ~~organizations~~ subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be

continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

Section 10. Subsection (4) and paragraph (a) of subsection (5) of section 400.506, Florida Statutes, are amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(4) A licensee ~~person~~ that provides, offers, or advertises to the public any service for which licensure is required under this section must include in such advertisement the license number issued to it by the Agency for Health Care Administration. The agency shall assess a fine of not less than $100 against a ~~any~~ licensee that ~~who~~ fails to include the license number when submitting the advertisement for publication, broadcast, or printing. The fine for a second or subsequent offense is $500.

(5)(a) In addition to the requirements of s. 408.812, a ~~any~~ person or entity that ~~who~~ owns, operates, or maintains an unlicensed nurse registry and ~~who~~, after receiving notification from the agency, fails to cease operation and apply for a license under this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continued operation is a separate offense.

Section 11. Subsections (1), (2), (4), and (5) of section 400.509, Florida Statutes, are amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.—

(1) A person or entity ~~Any organization~~ that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, a person or entity ~~any organization~~ that provides companion services or homemaker services must register with the agency. A person or entity ~~An organization~~ under contract with the Agency for Persons with Disabilities that ~~which~~ provides companion services only for persons with a developmental disability, as defined in s. 393.063, is exempt from registration.

(2) The requirements of part II of chapter 408 apply to the provision of services that require registration or licensure pursuant to this section and part II of chapter 408 and entities registered by or applying for such registration from the Agency for Health Care Administration pursuant to this section. Each applicant for registration and each registrant must comply with all provisions of part II of chapter 408. Registration or a license issued by the agency is required for the operation of a person or entity ~~an organization~~ that provides companion services or homemaker services.

(4) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the person or entity ~~organization~~ and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(5) A person or entity that offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

Section 12. Subsection (3) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(3) In accordance with s. 408.811, the agency shall conduct ~~annual inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance. The agency shall conduct~~ such inspections and investigations as are necessary in order to determine the state of compliance with ~~the provisions of~~ this part, part II of chapter 408, and applicable rules.

Section 13. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting~~; annual report~~.—

(1) ~~No later than December 31, 2019,~~ The agency shall adopt the national hospice outcome measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state.

(2) The agency shall~~:~~

~~(a)~~ make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices.

~~(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.~~

Section 14. Paragraphs (a), (b), (c), and (d) of subsection (4) of section 400.9905, Florida Statutes, are amended, and paragraphs (o), (p), and (q) are added to that subsection, to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B,

~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective

certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the scope of services authorized under their respective

certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.332, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 494 ~~405, subpart U~~; providers certified and providing only health care services within the

scope of services authorized under their respective certifications under 42 C.F.R. part 485, subpart B, ~~or~~ subpart H, or subpart J; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 486, subpart C; providers certified and providing only health care services within the scope of services authorized under their respective certifications under 42 C.F.R. part 491, subpart A; providers certified by the Centers for Medicare and Medicaid services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(o) Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in s. 628.703, with an entity licensed or certified under chapter 627 or chapter 641 which has $1 billion or more in total annual sales in this state.

(p) Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the

persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part.

(q) Medicaid providers.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

Section 15. Paragraph (c) of subsection (3) of section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

(3) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under ss. 408.8065(1) and ~~s.~~ 408.810(8). ~~As an alternative to submitting proof of financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic,~~

~~payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.~~

Section 16. Paragraph (i) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(i) Ensure that the clinic publishes a schedule of charges for the medical services offered to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule may group services by price levels, listing services in each price level. The schedule must be posted in a conspicuous place in the reception area of any clinic that is considered an ~~the~~ urgent care center as defined in s. 395.002(29)(b) and must include, but is not limited to, the 50 services most frequently provided by the clinic. ~~The schedule may group services by three price levels, listing services in each price level.~~ The posting may be a sign that must be at least 15 square feet in size or through an electronic messaging board that is at least 3 square feet in size. The failure of a clinic, including a clinic that is considered an urgent care center, to publish and post a schedule of charges as required by this section shall result in

a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 17. Paragraph (a) of subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and health care clinics~~, and multiphasic testing centers~~ and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

Section 18. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to, ~~:~~ case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, including patient- ~~with patient~~ and provider-specific identifiers ~~included~~, actual charge data by diagnostic groups or other bundled groupings as specified by rule, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and

demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents including ~~such as~~, but not limited to, ~~:~~ leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. ~~Reported~~ Data elements shall be reported electronically in accordance with rules adopted by the agency ~~rule 59E-7.012, Florida Administrative Code~~. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 19. Subsection (4) of section 408.0611, Florida Statutes, is amended to read:

408.0611 Electronic prescribing clearinghouse.—

(4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. ~~By January 31 of each year,~~ The agency shall annually publish a report on the progress of implementation of electronic prescribing on its Internet website ~~to the Governor and the Legislature~~. Information reported pursuant to this subsection shall include federal and private sector electronic prescribing

initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically transmitted.

Section 20. Paragraphs (i) and (j) of subsection (1) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

(i) The use of emergency department services by patient acuity level ~~and the implication of increasing hospital cost by providing nonurgent care in emergency departments~~. The agency shall annually publish information ~~submit an annual report~~ based on this monitoring and assessment on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

(j) The making available on its Internet website, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific

medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall annually publish information regarding ~~submit an annual status report on~~ the collection of data and publication of health care quality measures on its Internet website ~~to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees, due January 1~~.

Section 21. Subsection (5) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.—

~~(5) The agency shall publish annually a comprehensive report of state health expenditures. The report shall identify:~~

~~(a) The contribution of health care dollars made by all payors.~~

~~(b) The dollars expended by type of health care service in Florida.~~

Section 22. Section 408.802, Florida Statutes, is amended to read:

408.802 Applicability. ~~The provisions of~~ This part applies ~~apply~~ to the provision of services that require licensure as defined in this part and to the following entities licensed, registered, or certified by the agency, as described in chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102.

(2) Birth centers, as provided under chapter 383.

(3) Abortion clinics, as provided under chapter 390.

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394.

(6) Residential treatment facilities, as provided under part IV of chapter 394.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394.

(8) Hospitals, as provided under part I of chapter 395.

(9) Ambulatory surgical centers, as provided under part I of chapter 395.

(10) Nursing homes, as provided under part II of chapter 400.

(11) Assisted living facilities, as provided under part I of chapter 429.

(12) Home health agencies, as provided under part III of chapter 400.

(13) Nurse registries, as provided under part III of chapter 400.

(14) Companion services or homemaker services providers, as provided under part III of chapter 400.

(15) Adult day care centers, as provided under part III of chapter 429.

(16) Hospices, as provided under part IV of chapter 400.

(17) Adult family-care homes, as provided under part II of chapter 429.

(18) Homes for special services, as provided under part V of chapter 400.

(19) Transitional living facilities, as provided under part XI of chapter 400.

(20) Prescribed pediatric extended care centers, as provided under part VI of chapter 400.

(21) Home medical equipment providers, as provided under part VII of chapter 400.

(22) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400.

(23) Health care services pools, as provided under part IX of chapter 400.

(24) Health care clinics, as provided under part X of chapter 400.

~~(25) Multiphasic health testing centers, as provided under part I of chapter 483.~~

(25)~~(26)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765.

Section 23. Subsections (10) through (14) of section 408.803, Florida Statutes, are renumbered as subsections (11) through (15), respectively, subsection (3) is amended, and a new subsection (10) is added to that section, to read:

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

(3) "Authorizing statute" means the statute authorizing the licensed operation of a provider listed in s. 408.802 and includes chapters 112, 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765.

(10) "Low-risk provider" means a nonresidential provider, including a nurse registry, a home medical equipment provider, or a health care clinic.

Section 24. Paragraph (b) of subsection (7) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(7)

(b) An initial inspection is not required for companion services or homemaker services providers~~,~~ as provided under part III of chapter 400, ~~or~~ for health care services pools~~,~~ as provided under part IX of chapter 400, or for low-risk providers as provided in s. 408.811(1)(c).

Section 25. Subsection (2) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(2) PROVISIONAL LICENSE.—An applicant against whom a proceeding denying or revoking a license is pending at the time of license renewal may be issued a provisional license effective until final action not subject to further appeal. A provisional license may also be issued to an applicant making initial application for licensure or making application ~~applying~~ for a change of ownership. A provisional license must be limited in duration to a specific period of time, up to 12 months, as determined by the agency.

Section 26. Subsections (6) through (9) of section 408.809, Florida Statutes, are renumbered as subsections (5) through (8), respectively, and subsections (2) and (4) and present subsection (5) of that section are amended to read:

408.809 Background screening; prohibited offenses.—

(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check unless the person's fingerprints are enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit fingerprints electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print

arrest notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. ~~Until a specified agency is fully implemented in the clearinghouse created under s. 435.12,~~ The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of ~~the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Children and Families, or~~ the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;

(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and

(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an arrest awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

If, upon rescreening, a person who is currently employed or contracted with a licensee ~~as of June 30, 2014,~~ and was screened and qualified under s. ~~ss. 435.03 and~~ 435.04~~,~~ has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person.

~~(5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on July 31, 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by July 31, 2015, in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the~~

~~appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be:~~

~~(a) Individuals for whom the last screening was conducted on or before December 31, 2004, must be rescreened by July 31, 2013.~~

~~(b) Individuals for whom the last screening conducted was between January 1, 2005, and December 31, 2008, must be rescreened by July 31, 2014.~~

~~(c) Individuals for whom the last screening conducted was between January 1, 2009, through July 31, 2011, must be rescreened by July 31, 2015.~~

Section 27. Subsection (1) of section 408.811, Florida Statutes, is amended to read:

408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.—

(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has

reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(a) All inspections shall be unannounced, except as specified in s. 408.806.

(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules.

(c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance.

(d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure inspections based upon:

1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures.

2. Outcome measures that demonstrate quality performance.

3. Successful participation in a recognized, quality program.

4. Accreditation status.

5. Other measures reflective of quality and safety.

6. The length of time between inspections.

The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance.

Section 28. Subsection (24) of section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

~~(24) Multiphasic health testing centers, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(10).~~

Section 29. Subsections (1) and (2) of section 408.821, Florida Statutes, are amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(1) A licensee required by authorizing statutes and agency rule to have a comprehensive ~~an~~ emergency management ~~operations~~ plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:

(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.

(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.

(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.

(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.

(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management ~~operations~~ plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate

care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.

Section 30. Subsection (3) of section 408.831, Florida Statutes, is amended to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.—

(3) This section provides standards of enforcement applicable to all entities licensed or regulated by the Agency for Health Care Administration. This section controls over any conflicting provisions of chapters 39, 383, 390, 391, 394, 395, 400, 408, 429, 468, ~~483,~~ and 765 or rules adopted pursuant to those chapters.

Section 31. Section 408.832, Florida Statutes, is amended to read:

408.832 Conflicts.—In case of conflict between ~~the provisions of~~ this part and the authorizing statutes governing the licensure of health care providers by the Agency for Health Care Administration found in s. 112.0455 and chapters 383, 390, 394, 395, 400, 429, 440, ~~483,~~ and 765, ~~the provisions of~~ this part shall prevail.

Section 32. Subsection (9) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

~~(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer-driven benefit packages; and shall, by January 15, 2016, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.~~

Section 33. Paragraph (d) of subsection (10) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(10) PROGRAM EVALUATION.—The agency and the office shall:

~~(d) Jointly submit by March 1, annually, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.~~

Section 34. Effective upon becoming a law, paragraph (a) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the

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

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a)1. The agency may implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization

for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase.

2. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization.

3. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials.

4. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program. However, this subparagraph may not be construed to prevent the agency from

conducting retrospective reviews under s. 409.913, including reviews in which overpayment is suspected due to improper claiming, mistake, or any other reason that does not rise to the level of fraud or abuse.

Section 35. It is the intent of the Legislature that s. 409.905(5)(a), Florida Statutes, as amended by this act, confirm and clarify existing law.

Section 36. Subsection (8) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(8)(a) A level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following:

1. The ~~Each~~ provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity~~, seeking to participate in the Medicaid program~~

~~must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check~~.

2. Principals of the provider, who include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury,

to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application.

3. Any person who participates or seeks to participate in the Medicaid program by way of rendering services to Medicaid recipients or having direct access to Medicaid recipients, recipient living areas, or the financial, medical, or service records of a Medicaid recipient or who supervises the delivery of goods or services to a Medicaid recipient. This subparagraph does not impose additional screening requirements on any providers licensed under part II of chapter 408.

(b) Notwithstanding paragraph (a) ~~the above~~, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(c) ~~(a)~~ Paragraph (a) ~~This subsection~~ does not apply to:

1. A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national criminal history record checks must be borne by the nongovernmental provider or entity; or

2. Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more.

(d) ~~(b)~~ Background screening shall be conducted in accordance with chapter 435 and s. 408.809. The cost of the state and national criminal record check shall be borne by the provider.

Section 37. Section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Each January 15 ~~1~~, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a ~~joint~~ report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal

claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards,

benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(1) For the purposes of this section, the term:

(a) "Abuse" means:

1. Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

2. Recipient practices that result in unnecessary cost to the Medicaid program.

(b) "Complaint" means an allegation that fraud, abuse, or an overpayment has occurred.

(c) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance

with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

(f) "Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. As part of its ongoing fraud detection activities, the agency shall identify and monitor, by contract or otherwise, patterns of overutilization of Medicaid services based on state averages. The agency shall track

Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

(3) The agency may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing; to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the agency, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to 1 year. Unless the agency has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days after receipt of complete documentation by the agency for review. If there is reliable evidence of fraud,

misrepresentation, abuse, or neglect, claims shall be adjudicated for denial of payment within 180 days after receipt of complete documentation by the agency for review.

(4) Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review

organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

(6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice. Any notice required to be given to the agency by this section must be sent to the agency at an address designated by rule.

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

(8) The agency shall not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. This section does not apply:

(a) In instances involving bona fide emergency medical conditions as determined by the agency;

(b) To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or outpatient setting, or nursing home;

(c) To bona fide pro bono services by preapproved non-Medicaid providers as determined by the agency;

(d) To prescribing physicians who are board-certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program;

(e) To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program;

(f) To other physicians who are not enrolled in the Medicaid program but who provide a medically necessary service or prescription not otherwise reasonably available from a Medicaid-enrolled physician; or

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep the agency informed of the location of the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-

related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(10) Payments for the services of billing agents or persons participating in the preparation of a Medicaid claim shall not be based on amounts for which they bill nor based on the amount a provider receives from the Medicaid program.

(11) The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

(12) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the agency takes final agency action with respect to the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Attorney General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

(13) The agency shall terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 408.809(4), s. 409.907(10), or s. 435.04(2). If the agency determines that the provider did not participate or acquiesce in the offense, termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action.

(14) If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in

effect. The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state. This sanction is in addition to all other remedies provided by law.

(15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

(a) The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;

(b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;

(c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

(f) The provider or person who ordered, authorized, or prescribed the care, services, or supplies has furnished, or ordered or authorized the furnishing of, goods or services to a recipient which are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality;

(g) The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;

(h) The provider or an authorized representative of the provider, or a person who ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

(j) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(k) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(l) The provider is charged by information or indictment with fraudulent billing practices or an offense referenced in subsection (13). The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;

(m) The provider or a person who ordered, authorized, or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

(n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;

(o) The provider has failed to comply with the notice and reporting requirements of s. 409.907;

(p) The agency has received reliable information of patient abuse or neglect or of any act prohibited by s. 409.920; or

(q) The provider has failed to comply with an agreed-upon repayment schedule.

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

(a) Suspension for a specific period of time of not more than 1 year. Suspension precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(b) Termination for a specific period of time ranging from more than 1 year to 20 years. Termination precludes participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid

provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

(d) Immediate suspension, if the agency has received information of patient abuse or neglect or of any act prohibited by s. 409.920. Upon suspension, the agency must issue an immediate final order under s. 120.569(2)(n).

(e) A fine, not to exceed $10,000, for a violation of paragraph (15)(i).

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

(g) Prepayment reviews of claims for a specified period of time.

(h) Comprehensive followup reviews of providers every 6 months to ensure that they are billing Medicaid correctly.

(i) Corrective-action plans that remain in effect for up to 3 years and that are monitored by the agency every 6 months while in effect.

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

If a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation, the agency shall impose the sanction of termination for cause against the provider. The agency's termination with cause is subject to hearing rights as may be provided under chapter 120. The Secretary of Health Care Administration may make a determination that imposition of a sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive may not be imposed.

(17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted

in either a criminal conviction or in administrative sanction or penalty.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

(18) The agency may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group.

(19) The agency shall establish a process for conducting followup reviews of a sampling of providers who have a history

of overpayment under the Medicaid program. This process must consider the magnitude of previous fraud or abuse and the potential effect of continued fraud or abuse on Medicaid costs.

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the

case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note

was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

(23)(a) In an audit, ~~or~~ investigation, or enforcement action for ~~of~~ a violation committed by a provider which is conducted or taken pursuant to this section, the agency or contractor is entitled to recover any and all investigative and~~,~~ legal costs incurred as a result of such audit, investigation, or enforcement action. Such costs may include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on the case, and any other expenses incurred by the agency or contractor that are associated with the case, including any~~, and~~ expert witness costs and attorney fees incurred on behalf of the agency or contractor if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

(24) If the agency imposes an administrative sanction pursuant to subsection (13), subsection (14), or subsection (15), except paragraphs (15)(e) and (o), upon any provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider who is regulated by another

state entity, the agency shall notify that other entity of the imposition of the sanction within 5 business days. Such notification must include the provider's or person's name and license number and the specific reasons for sanction.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

(b) The agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state.

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must

be made within 30 days after the date of the final order, which is not subject to further appeal.

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

(e) The agency may institute amnesty programs to allow Medicaid providers the opportunity to voluntarily repay overpayments. The agency may adopt rules to administer such programs.

(26) The agency may impose administrative sanctions against a Medicaid recipient, or the agency may seek any other remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, if the agency finds that a recipient has engaged in solicitation in violation of s. 409.920 or that the recipient has otherwise abused the Medicaid program.

(27) When the Agency for Health Care Administration has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, the agency, after notice to the provider, shall:

(a) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:

1. Makes repayment in full; or

2. Establishes a repayment plan that is satisfactory to the Agency for Health Care Administration.

(b) Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to chapter 120, medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

(28) Venue for all Medicaid program integrity cases lies in Leon County, at the discretion of the agency.

(29) Notwithstanding other provisions of law, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs may review a provider's Medicaid-related and non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within

30 days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

(31) If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer. Upon issuance of a final order, the outstanding balance of the amount determined to constitute the overpayment and fines is due. If a provider fails to make payments in full, fails to enter into a satisfactory repayment plan, or fails to comply with the terms of a repayment plan or settlement agreement, the agency shall withhold reimbursement payments for Medicaid services until the amount due is paid in full.

(32) Duly authorized agents and employees of the agency shall have the power to inspect, during normal business hours, the records of any pharmacy, wholesale establishment, or manufacturer, or any other place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, or kept for sale, for the purpose of verifying the amount of drugs and medical supplies ordered, delivered, or purchased by a provider. The agency shall provide at least 2 business days' prior notice of any such inspection. The notice must identify the provider whose records will be inspected, and the inspection

shall include only records specifically related to that provider.

(33) In accordance with federal law, Medicaid recipients convicted of a crime pursuant to 42 U.S.C. s. 1320a-7b may be limited, restricted, or suspended from Medicaid eligibility for a period not to exceed 1 year, as determined by the agency head or designee.

(34) To deter fraud and abuse in the Medicaid program, the agency may limit the number of Schedule II and Schedule III refill prescription claims submitted from a pharmacy provider. The agency shall limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if the agency or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.

(35) The Office of Program Policy Analysis and Government Accountability shall provide a report to the President of the Senate and the Speaker of the House of Representatives on a biennial basis, beginning January 31, 2006, on the agency's efforts to prevent, detect, and deter, as well as recover funds lost to, fraud and abuse in the Medicaid program.

(36) The agency may provide to a sample of Medicaid recipients or their representatives through the distribution of explanations of benefits information about services reimbursed by the Medicaid program for goods and services to such recipients, including information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation, information on how to report criminal Medicaid fraud to the Medicaid Fraud Control Unit's toll-free hotline number, and information about the rewards available under s. 409.9203. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for Medicaid certified match services as described in ss. 409.9071 and 1011.70.

(37) The agency shall post on its website a current list of each Medicaid provider, including any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, who has been terminated for cause from the Medicaid program or sanctioned under this section. The list must be searchable by a variety of search parameters and provide for the creation of formatted lists that may be printed or imported into other applications, including spreadsheets. The agency shall update the list at least monthly.

(38) In order to improve the detection of health care fraud, use technology to prevent and detect fraud, and maximize the electronic exchange of health care fraud information, the agency shall:

(a) Compile, maintain, and publish on its website a detailed list of all state and federal databases that contain health care fraud information and update the list at least biannually;

(b) Develop a strategic plan to connect all databases that contain health care fraud information to facilitate the electronic exchange of health information between the agency, the Department of Health, the Department of Law Enforcement, and the Attorney General's Office. The plan must include recommended standard data formats, fraud identification strategies, and specifications for the technical interface between state and federal health care fraud databases;

(c) Monitor innovations in health information technology, specifically as it pertains to Medicaid fraud prevention and detection; and

(d) Periodically publish policy briefs that highlight available new technology to prevent or detect health care fraud and projects implemented by other states, the private sector, or the Federal Government which use technology to prevent or detect health care fraud.

Section 38. Subsection (1) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(1) Beginning with the contract procurement process initiated during the 2023 calendar year, the agency shall establish a 6-year ~~5-year~~ contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in July 2017.

Section 39. Paragraph (b) of subsection (5) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act

and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process. Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 ~~5~~ years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.

Section 40. Subsection (6) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

~~(6) In addition to the license categories available in s. 408.808, a provisional license may be issued to an applicant making initial application for licensure or making application~~

~~for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.~~

Section 41. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

~~(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, the area agencies on aging, the Florida Statewide Advocacy Council, the State Long-Term Care Ombudsman Program, and state and local ombudsman councils. The Department of Children and Families shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.~~

Section 42. Subsection (2) of section 429.35, Florida Statutes, is amended to read:

429.35 Maintenance of records; reports.—

(2) Within 60 days after the date of an ~~the biennial~~ inspection conducted ~~visit required~~ under s. 408.811 or within 30 days after the date of an ~~any~~ interim visit, the agency shall forward the results of the inspection to the local ombudsman council in the district where the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

Section 43. Subsection (2) of section 429.905, Florida Statutes, is amended to read:

429.905 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.—

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection ~~and at least biennially~~ to ensure adequate space and

sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule. For the purpose of this subsection, the term "day" means any portion of a 24-hour day.

Section 44. Subsection (2) of section 429.929, Florida Statutes, is amended to read:

429.929 Rules establishing standards.—

~~(2) Pursuant to this part, s. 408.811, and applicable rules, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of provider groups. These standards shall be included in rules adopted by the agency.~~

Section 45. Part I of chapter 483, Florida Statutes, is repealed.

Section 46. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1,

2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 895 Insurance
SPONSOR(S): Insurance & Banking Subcommittee; Santiago
TIED BILLS: **IDEN./SIM. BILLS:** SB 1606

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	14 Y, 0 N, As CS	Lloyd	Cooper
2) Appropriations Committee		Helpling	Pridgeon
3) Commerce Committee			

SUMMARY ANALYSIS

Hurricane Catastrophe Fund – The Florida Hurricane Catastrophe Fund, which is a state created tax-exempt trust fund that acts as a reinsurer to the Florida property insurance market, reimburses insurers for collateral protection insurance insurers must place on indebted properties when the owner's insurance policy has lapsed. This "force placed" insurance can differ in value from the value of the insurance the owner had purchased. The bill allows insurers to recover the value of the "force placed" insurance, as an alternative to the last reported value associated with the property owner's lapsed insurance policy, which is the current standard.

Motor Vehicle Insurance –

- Personal injury protection and property damage coverage are required to register a vehicle and bodily injury coverage is required when an accident occurs. Law enforcement does not have real time access to verify motor vehicle insurance. Contingent on receipt of funding (the bill provides none), the bill requires the creation of the motor vehicle insurance online verification system, by the Department of Highway Safety and Motor Vehicles (DHSMV), and a task force to assist, review, and report on the implementation of the system.
- Currently, an insurer is only required to collect one month's premium at the inception of a motor vehicle insurance policy; prior to July 2019, this was two month's premium. The insurer is prohibited from cancelling the policy in the first 60 days, unless the initial payment fails. The bill reduces the cancellation prohibition from 60 days to 30 days.

Travel Insurance – Travel insurance is a limited line of insurance. There are few requirements in the Florida Insurance Code specifically regulating travel insurance. Using the Travel Insurance Model Act, from the National Association of Insurance Commissioners, the bill expands the Florida Insurance Code to include a new chapter of statutes to regulate the transaction of travel insurance. The Model Act is generally consistent with Florida's current regulation of travel insurance, but there are some differences.

Surplus Lines Agent Affidavits – Surplus lines agents must obtain coverage rejections from Florida insurers before "exporting" a policy to a surplus lines insurer. The agent is required to file an affidavit quarterly attesting to the required coverage rejections. The bill eliminates the required affidavit (the information reported on the affidavit is otherwise available in electronic data filings).

Workers' Compensation Insurance Reporting Requirements – Workers' compensation insurance carriers are required to record and report certain loss, expense, and claims experience to aid the Office of Insurance Regulation in making determinations concerning the adequacy of workers' compensation experience for ratemaking purposes. Currently, insurers in receivership stop reporting data because they are no longer members of the rating organization that handles the date reporting. The bill requires insurers in receivership to continue reporting the required data.

Agent Licensing – To sell a motor vehicle servicing agreement, service warranty agreement, or home warranty contract, one must be licensed as a salesperson or sales representative, depending on the type of agreement or contract sold. The bill allows a licensed general lines agent or personal lines agent to sell such agreements and contracts without a separate salesperson or sales representative license.

The bill has a significant, negative impact on DHSMV and the Department of Financial Services. See *Fiscal Analysis & Economic Impact Statement.*

The bill is effective on July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Hurricane Catastrophe Fund – Collateral Protection Insurance

Background

The Florida Hurricane Catastrophe Fund (FHCF)[1] is a tax-exempt trust fund created by the Legislature in 1993 as a form of reinsurance for residential property losses. The FHCF is administered by the State Board of Administration and reimburses property insurers for a selected percentage of hurricane losses to residential property above the insurer's retention (deductible). As a condition of doing business in Florida, property insurers are required to enter into reimbursement contracts with FHCF. The purpose of the FHCF is to protect and advance the state's interest in maintaining insurance capacity in Florida by providing reimbursements to insurers for a portion of their catastrophic hurricane losses.

The FHCF reimburses its participating insurers for losses on covered policies, subject to limitations.[2] Collateral protection insurance[3] is included as a covered policy.[4] It protects both a borrower's and a lender's financial interest and is covered at the value of the last known policy. Collateral protection insurance is placed by an insurer when a borrower's policy on the property has lapsed. Sometimes, the insurer is unable to obtain correct information from the homeowner and places coverage at an amount other than the amount of the homeowner's lapsed policy. This can create a discrepancy between the coverage in place and the amount of the homeowner's lapsed policy, which is the value currently covered by the FHCF.

Effect of the Bill

The bill allows the value of the lender's force-placed collateral protection insurance to be reimbursed as a covered policy, if the lender has notified the homeowner in writing of the coverage amount and the homeowner has not requested the insurer to issue a policy for a different amount.

Motor Vehicle Insurance

MOTOR VEHICLE INSURANCE ONLINE VERIFICATION SYSTEM

Background

Chapter 324, F.S., is the Financial Responsibility Law of 1955.[5] The intent of chapter 324, F.S., is to:

> [R]ecognize the existing privilege to own or operate a motor vehicle when such vehicles are used with due consideration for others and their property, and to promote safety and provide financial security requirements for such owners or operators whose responsibility it is to recompense others for injury to person or property caused by the operation of a motor vehicle. Therefore, the law requires that the operator of a motor vehicle involved in a crash or convicted of certain traffic offenses is required to provide proof of financial ability to respond for damages in future accidents as a requisite to his or her future exercise of operating a motor vehicle.[6]

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[1] S. 215.555, F.S.
[2] S. 215.555(1)(d), F.S.
[3] "Collateral protection insurance" means commercial property insurance under which a creditor is the primary beneficiary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation of such coverage is triggered by the mortgagor's failure to maintain insurance coverage as required by the mortgage or other lending document. Collateral protection insurance is not residential coverage. S. 624.6085, F.S.
[4] S. 215.555(1)(c), F.S.
[5] S. 324.251, F.S.
[6] S. 324.011, F.S.

Section 316.646, F.S., requires persons required by law to maintain certain motor vehicle insurance coverage, to possess proof of insurance, and specifies when the person is required to provide proof of motor vehicle insurance. If a person is cited for violating this requirement and can provide proof of insurance that was valid and the time of the citation, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10.[7]

Section 320.02, F.S., requires the registration of motor vehicles. Proof of purchase of personal injury protection and property damage insurance must be provided in order to register a motor vehicle. If the registrant is required to purchase bodily injury liability coverage as a result of a conviction for driving under the influence, then proof of bodily injury liability coverage is also required at registration.[8]

Section 324.0221, F.S., requires motor vehicle insurers to notify the Department of Highway Safety & Motor Vehicles (DHSMV) of cancellations or nonrenewals of motor vehicle insurance within 10 days after the processing or effective date of each cancellation or nonrenewal. Furthermore, the statute requires insurers to notify DHSMV within 10 days of the issuance of new insurance policies from persons not previously insured by that insurance company. When DHSMV receives a notice of cancellation from an insurer, DHSMV's system will attempt to verify if additional insurance has been provided and if the registration for the vehicle is still valid. If no additional insurance is verified for the registered vehicle after 20 days, the system will create a financial responsibility case on the owner or registrant's driver license and registration. Five days after the case is created a letter is generated and submitted to the vehicle owner or registrant notifying him or her that replacement proof of insurance is required for the registered vehicle. If insurance information is not provided, or the owner or registrant does not cancel the registration, the owner or registrant's driver license and registration will be suspended at 12:01 a.m. on the fifteenth day from the date of the postmarked letter.[9]

Currently, there is no mechanism in place to determine in real time that a proof of insurance coverage for the required financial responsibility is valid. The current process requires insurance carriers to report insurance information so that it can be compared to DHSMV-maintained vehicle registration. Under this reporting process, any vehicle registrations that are not tied to an insurance record are considered uninsured.[10]

A number of states have implemented online motor vehicle insurance verification programs including Alabama,[11] Oklahoma,[12] Texas,[13] and Tennessee.[14] Most of the states that have implemented online motor vehicle verification programs require that the systems generally meet standards developed by the Insurance Industry Committee on Motor Vehicle Administration (IICMVA).[15]

Several states that have instituted motor vehicle insurance verification programs have reported significant reductions in the number of uninsured motorists.[16]

Effect of the Bill

The provisions of the bill relating to and requiring the creation of a Motor Vehicle Insurance Online Verification System and the Motor Vehicle Insurance Online Verification Task Force do not go into effect until a specific appropriation is passed for this purpose.

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[7] S. 318.18(2)(b)3., F.S.
[8] S. 320.02(5), F.S.
[9] S. 322.251(2), F.S.
[10] *See* s. 324.011, F.S.
[11] Alabama Act 2011-688.
[12] Okla. Stat. tit. 47, s. 7-600.2.
[13] Tex. Transp. Code Ann. ss. 601.053(c) & 601.191.
[14] Tenn. Code Ann. ss. 55-12-201 – 55-12-215.
[15] The Insurance Industry Committee on Motor Vehicle Administration (IICMVA) is an all-industry advisory group formed in January 1968 as the official liaison between the insurance industry and Motor Vehicle Departments in the US and Canada. https://www.iicmva.com/ (last visited Jan. 25, 2020).
[16] Alice Holbrook, *Are Auto Insurance Verification Programs a Good Idea?*, available at https://www.nerdwallet.com/blog/insurance/auto-insurance-verification-programs-good-idea/ (last visited Jan. 25, 2020).

Motor Vehicle Insurance Online Verification System

The bill creates s. 324.252, F.S., requiring DHSMV to establish an online verification system for motor vehicle insurance. The system's goal is to identify uninsured motorists and aid DHSMV in enforcing the financial responsibility law. The online verification system must:

- Be accessible through electronic means for use by any government agency, including any court or law enforcement agency, in carrying out its functions, or any private person or entity acting on behalf of a federal, state, or local agency in carrying out its functions, any other entities authorized by DHSMV, and insurers authorized by OIR to offer motor vehicle insurance. DHSMV may also create a web site for public use in confirming insurance coverage.
- Send real time requests to insurers for verification of evidence of insurance for motor vehicles registered in this state, and receive confirmation in real time from insurers via electronic means consistent with IICMVA specifications and standards, with enhancements, additions, and modifications, as DSHMV requires. However, the enhancements, additions, and modifications may not conflict with, nullify, or add requirements that are inconsistent with IICMVA specifications or standards.
- Be operational 36 months after being funded. The task force must conduct a pilot program for at least nine months to test the system before statewide use. The system may not be used in any enforcement action until successful completion of the pilot program.
- Be available 24 hours a day, except for permitted downtime for system maintenance and other work, as needed, to verify the insurance status of any vehicle registered in this state through the insurer's National Association of Insurance Commissioners (NAIC) company code, Florida company code, in combination with other identifiers such as vehicle identification number, car make, car model, registered owner's name, policy number, levels/type of coverage, or other characteristics or markers as specified by the task force.
- Include appropriate safeguards and controls to prevent unauthorized access.
- Include a disaster recovery plan to ensure service continuity in the event of a disaster.
- Include information that enables DHSMV to make inquiries of evidence of insurance by using multiple data elements for greater matching accuracy, specifically the insurer's NAIC company code, in combination with other identifiers such as vehicle identification number, policy number, or other characteristics or markers as specified by the task force or DHSMV.
- Include a self-reporting mechanism for insurers with fewer than 2,000 vehicles insured within this state or for individual entities that are self-insured.

The bill provides DHSMV the following powers and duties:

- Upon advance notice, DHSMV must allow online services established by an insurer to have reasonable downtime for system maintenance and other work, as needed. An insurer is not subject to administrative penalties or disciplinary actions when its online services are not available under such circumstances or when an outage is unplanned by the insurer and is reasonably outside its control.
- Upon recommendation of the task force, DHSMV may develop and operate the system or procure a private vendor that has personnel with extensive operational and management experience in the development, deployment, and operation of insurance online verification systems.
- DSHMV and its private vendor, if any, must each maintain a contact person for the insurers during the establishment, implementation, and operation of the system.
- DHSMV may enter into use contracts with public and private entities accessing the system.
- DHSMV must maintain a historical record of the system data for three years after the date of any verification request and response.

An insurance company authorized to issue insurance policies for motor vehicles registered in this state:

- Must comply with the verification requirements of motor vehicle insurance for every motor vehicle insured by that company in this state.
- Must maintain policyholder records in order to confirm insurance coverage for three years after the date of any verification request and response.
- Must cooperate with DHSMV in establishing, implementing, and maintaining the system.
- Is immune from civil liability for good faith efforts to comply with statutory requirements related to the online verification system. An online verification request or response may not be used as the basis of a civil action against an insurer.

Beginning 18 months after the system is implemented, a law enforcement officer, during a traffic stop or crash investigation, must request information from the online verification system to establish compliance with chapter 324, F.S. Use of the system prior to this requirement is discretionary.

The motor vehicle insurance online verification system does not apply to commercial motor vehicle coverage.[17] However, insurers of commercial motor vehicles may participate in the online verification system on a voluntary basis.

The bill amends s. 320.02(5), F.S., providing that upon implementation of the motor vehicle insurance online verification system, the online verification may be used to verify motor vehicle insurance at the time of motor vehicle registration.

The bill amends s. 324.0221, F.S., requiring an insurer to transmit weekly, in a DHSMV-prescribed format, the insurer's records of all active insurance policies[18] to enable DHSMV to identify uninsured vehicles.

The bill authorizes DHSMV to verify information from an insurer as provided in s. 324.252, F.S. This does not relieve an insurer from the reporting requirements in s. 324.0221, F.S.

DHSMV may adopt rules to administer the motor vehicle insurance online verification system.

Motor Vehicle Insurance Online Verification Task Force

The bill creates, within DHSMV, the Motor Vehicle Insurance Online Verification Task Force (task force). The task force must:

- Facilitate the implementation of the motor vehicle insurance online verification system.
- Assist in the development of a detailed guide for insurers by providing data fields and other information necessary for compliance with the online verification system.
- Coordinate a pilot program and conduct the program for at least nine months to test the online verification system and identify necessary changes to be implemented before statewide use.
- Issue recommendations based on periodic reviews of the online verification system.

The task force consists of 10 voting members and one nonvoting member. DHSMV's executive director, who is a nonvoting member, serves as its chair. The 10 voting members must be appointed by July 31 of the year the task force is funded, as follows:

- Three appointed by DHSMV's executive director, representing the Florida Highway Patrol, the Division of Motorist Services, and the Information Systems Administration.
- One appointed by the Commissioner of Insurance, representing the Office of Insurance Regulation (OIR).

[17] The bill defines "commercial motor vehicle coverage" as any coverage provided to an insured under a commercial coverage form and rated from a commercial manual approved by OIR.

[18] This is commonly known as the insurance company's "book of business."

- Three appointed by the Chief Financial Officer, representing the motor vehicle insurance industry, as follows:
  - One member representing the motor vehicle insurer with the largest national market share as of December 31 of the year prior to appointment.
  - One member representing the motor vehicle insurer with the largest Florida market share as of December 31 of the year prior to appointment.
  - One member selected from a list of representatives recommended by the IICMVA.
- One appointed by the Chief Financial Officer, representing the Department of Financial Services (DFS).
- One appointed by the secretary of the Department of Management Services, representing the Division of State Technology.
- One member who is a member of local law enforcement, appointed by DHSMV's executive director.

By September 30 of the year the task force is funded, the task force must meet to establish procedures for conducting its business, and electing a vice chair. The task force must meet at the call of the chair, who is responsible for preparing the agenda for each meeting with the consent of the task force. A majority of the voting members of the task force constitutes a quorum, and a quorum is necessary for the purpose of voting on any action or recommendation of the task force. All meetings must be held in Tallahassee.

DSHMV must provide the task force members with administrative and technical support. Task force members serve without compensation and are not entitled to reimbursement for per diem or travel expenses.

By July 1 of the third year following funding, the task force must complete its work and submit its final report evaluating the online verification system's effectiveness and making recommendations for system enhancements to DHSMV, the President of the Senate, and the Speaker of the House of Representatives. Upon submission of the report, the task force expires.

PREPAYMENT OF PREMIUM ON INITIAL POLICY PURCHASE AND CANCELLATION OF POLICIES

Background

Law requires that a policy[19] of private passenger motor vehicle insurance or a binder[20] for such a policy may be initially issued only if, before the effective date of such binder or policy, the insurer or agent has collected from the insured an amount equal to one month's premium.[21] An insurer, agent, or premium finance company may not, directly or indirectly, take any action resulting in the insured having paid from the insured's own funds an amount less than the required one month premium. This applies without regard to whether the premium is financed by a premium finance company or is paid pursuant to a periodic payment plan of an insurer or an insurance agent. The statute also provides various circumstances where this would not apply including policy renewal, coverage to active duty or former military personnel, and payments by automatic payroll deduction or electronic funds transfer. The insurer may not cancel the policy during the first 60 days, unless the reason for the cancellation is the issuance of a check for the premium that is dishonored for any reason or any other type of premium payment that was subsequently determined to be rejected or invalid.[22]

Prior to July 2019, insurers were required to collect two months of premium prior to issuing a private passenger motor vehicle policy. This was reduced to one month's premium by CS/CS/CS HB 301

[19] Section 627.7295(1)(a), F.S., defines "policy" as a motor vehicle insurance policy that provides personal injury protection coverage, property damage liability coverage, or both.
[20] Section 627.7295(1)(b), F.S., defines "binder" as a binder that provides motor vehicle personal injury protection and property damage liability coverage.
[21] S. 627.7295(7), F.S.
[22] S. 627.7295(4), F.S.

(2019).[23] However, the cancellation limitation was not reduced at the same time. Now an insurer is only required to collect one month's premium, but cannot cancel the policy for 60 days.

Effect of the Bill

The bill reduces the limitation on insurer cancellation from 60 days to 30 days consistent with the 2019 law change that reduced the required collection of initial premium from two month's premium to one month's premium.

Travel Insurance

Background

The Florida Insurance Code[24] generally regulates travel insurance. OIR currently reviews policies relating to travel insurance, pursuant to s. 626.321 (1)(c), F.S. DFS is responsible for licensing of individuals and entities that sell travel insurance.[25]

TRAVEL INSURANCE RATES AND FORMS

Policies and certificates of travel insurance may provide coverage for risks incidental to travel, planned travel, or accommodations while traveling, including, but not limited to, accidental death and dismemberment of a traveler; trip or event cancellation, interruption, or delay; loss of or damage to personal effects or travel documents; damages to travel accommodations; baggage delay; emergency medical travel or evacuation of a traveler; or medical, surgical, and hospital expenses related to an illness or emergency of a traveler. Such policy or certificate may be issued for longer terms, but each policy or certificate must be limited to coverage for travel or use of accommodations of no longer than 90 days.[26]

A group policy for travel insurance is exempt from filing rates and forms.[27] Currently, a travel insurance policy that is sold directly from an insurance company to a consumer is required to make annual rate filings.[28] Regardless of whether a travel insurance rate is required to be filed, it may not be excessive, inadequate, or unfairly discriminatory.[29]

TRAVEL INSURANCE AGENT LICENSING

A travel insurance agent or agency license may be issued to only:[30]

- A full-time salaried employee of a common carrier or a full-time salaried employee or owner of a transportation ticket agency and may authorize the sale of such ticket policies only in connection with the sale of transportation tickets, or to the full-time salaried employee of such an agent. No such policy shall be for a duration of more than 48 hours or for the duration of a specified one-way trip or round trip.
- An individual that is:
    - The developer of a timeshare plan that is the subject of an approved public offering statement under chapter 721, F.S.;

[23] Chapter 2019-108, F.S.
[24] The Florida Insurance Code is chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S. S. 624.01, F.S.
[25] S. 626.321, F.S. A travel insurance license is a limited license.
[26] S. 626.321(1)(c), F.S. A policy or certificate providing coverage for air ambulatory services only may exceed the 90 day limit on travel/accommodation (due to illness or injury, and unforeseeable length of time may pass before return home by air ambulance).
[27] Travel insurance is not subject to rate requirements listed in s. 627.062 (2)(a), F.S., or s. 627.062 (2)(f), F.S., as long as it is "issued as a master group policy with a situs in another state where each certificate holder pays less than $30 in premium for each covered trip and where the insurer has written less than $1 million in annual written premiums in the travel insurance product in this state during the most recent calendar year." S. 627.062 (3)(d)1.n., F.S.
[28] Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance is required to complete annual filings. s. 627.0645 (1), F.S.
[29] S. 627.062(1), F.S.
[30] S. 626.321(1)(c), F.S.

    - A managing entity operating a timeshare plan approved under chapter 721, F.S.;
    - A seller of travel as defined in chapter 559, F.S.;
    - A seller of travel as defined in chapter 559, F.S.; or
    - A subsidiary or affiliate of any of the entities described above.
- The full-time salaried employee of a licensed general lines agent or to a business entity that offers motor vehicles for rent or lease if insurance sales activities authorized by the license are in connection with and incidental to the rental or lease of a motor vehicle.
    - A license issued to a business entity that offers motor vehicles for rent or lease encompasses each office, branch office, employee, authorized representative located at a designated branch, or place of business making use of the entity's business name in order to offer, solicit, and sell insurance pursuant to this paragraph.
    - The application for licensure must list the name, address, and phone number for each office, branch office, or place of business that is to be covered by the license. The licensee shall notify the department of the name, address, and phone number of any new location that is to be covered by the license before the new office, branch office, or place of business engages in the sale of insurance pursuant to this paragraph. The licensee must notify the department within 30 days after closing or terminating an office, branch office, or place of business. Upon receipt of the notice, the department shall delete the office, branch office, or place of business from the license.
    - A licensed and appointed entity is directly responsible and accountable for all acts of the licensee's employees.

The travel insurance agency license is only issued to the business entity. Each of its branches must be appointed by the insurers the agency and branch represents and the appointments must be filed with DFS. Appointments are subject to an original appointment filing fee and a renewal fee every 24 months.[31]

TRAVEL INSURANCE MODEL ACT

In 2016, the National Conference of Insurance Legislators began considering the adoption of a Travel Insurance Model Act. The final version of this Travel Insurance Model Act was approved on July 15, 2017. NAIC used this model act to create a model of their own. At least 42 states have implemented portions of the NAIC Model Act.[32]

Effect of the Bill

The bill incorporates NAIC's Travel Insurance Model Act, MDL-635,[33] into the Florida Insurance Code.

The bill creates a new chapter of F.S. entitled "Travel Insurance." The chapter applies to:

- Travel insurance covering any resident of Florida that is sold, solicited, negotiated, or offered in this state, as well as policies and certificates that are delivered or issued in this state; and
- Policies and certificates that are delivered or issued for delivery in Florida.

Specific provisions outlined in this chapter supersede any general provisions otherwise applicable to travel insurance. This chapter does not apply to:

- Major medical plans that provide medical protection for travelers with trips lasting longer than 6 months; and
- Travel assistance services and cancellation waivers.

[31] S. 626.501(9), F.S. *See also* s. 626.381, F.S.
[32] National Association of Insurance Commissioners, *Travel Insurance Model Act* (4th quarter, 2018), https://www.naic.org/store/free/MDL-632.pdf (last visited Jan. 25, 2020).
[33] *Id.*

A person offering, soliciting, or negotiating travel insurance or protection plans may not do so using an opt-out option that requires a consumer to take an affirmative action when purchasing a trip. Any person offering travel insurance is subject to the Unfair Insurance Trade Practices Act (UITPA),[34] unless otherwise specified. If a conflict arises between UITPA and this chapter, the provisions of this chapter will control. If a destination jurisdiction requires travel insurance coverage, it is not an unfair trade practice to require the consumer to purchase the required coverage through the travel retailer or the limited lines insurance producer supplying the trip or package. A consumer also has the option to obtain and provide proof of coverage from another source, provided it meets the jurisdiction's requirements and is purchased prior to departure. It is not an unfair trade practice to market travel insurance directly to a consumer online, as long as the web page provides an accurate summary or short description of the coverage and the consumer has access to the full policy provisions through electronic means. Conversely, a person commits an unfair trade practice under UITPA if he or she offers or sells a policy that could never result in payment of any claims or markets blanket travel insurance coverage as free.

A person may act or represent himself or herself as a travel administrator[35] if he or she is a licensed and appointed property and casualty insurance producer in Florida, is appointed as a managing agent in Florida, or holds a valid third party administrator license. A travel administrator and its employees are exempt from the licensing requirements listed in chapter 626, part VI, F.S. An insurer has the responsibility of ensuring a travel administrator acts in accordance with this chapter and maintains books and records, which must be available to DFS upon request.

The bill requires travel insurance documents to be provided to a consumer before purchase. Fulfillment materials must be sent to the purchaser of a travel protection plan after purchase, confirming the purchase and outlining the details of the plan. Fulfillment materials must include whether the travel insurance is primary or secondary to other applicable coverage and whether the policy has preexisting condition exclusions. A policyholder or certificate holder can cancel a policy or certificate for a full refund up to 15 days after date of delivery, if delivered by postal mail, and 10 days after date of delivery, if delivered by means other than postal mail.

For purposes of rates and forms, the bill classifies travel insurance under the inland marine line of insurance. Coverage for sickness, accident, disability, or death during travel may be classified and filed under the accident and health or the inland marine line of insurance. Travel insurance may be in the form of an individual, group or blanket policy. A group or blanket policy is classified as commercial inland marine insurance under s. 627.021(2)(d), F.S. A policy not issued to a commercial entity and primarily used for personal, family, or household purposes is classified as personal inland marine insurance and is not subject to the rate requirements under s. 627.062, F.S.

The bill would require an insurer to pay a premium tax, as required under s. 624.509, F.S., on travel insurance premiums paid by the primary policyholder or certificate holder and by the blanket policyholder.[36] The premium paid does not include amounts received for travel assistance services or cancellation waivers.

TRAVEL INSURANCE AGENT LICENSING

The bill revises current travel insurance agent and agency licensing. The following individuals and entities will require licensing and appointment to transact travel insurance:

- A limited lines travel insurance producer, which is:
    - A licensed administrator or third-party administrator;
    - A licensed insurance producer, including a limited lines producer; or

[34] Chapter 626, Part IX, F.S.

[35] A travel administrator is a person who directly or indirectly underwrites policies for, collects charges, collateral, or premiums from, or adjusts or settles claims on residents of this state, in connection with travel insurance.

[36] This does not appear to be a new tax. Travel insurance is already subject to premium tax under the Florida Insurance Code. This provision appears to be included to clarify the applicability of premium tax requirements to the newly created chapter 647, F.S.

    - A travel administrator.
- A general lines or personal lines agent.

The following individual or entity must be registered and appointed (under a licensed limited lines travel insurance producer) to transact travel insurance:

- Travel retailer, which is a business entity that:
    - Makes, arranges, or offers planned travel.
    - Disseminates travel insurance, under conditions specified in the bill, as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

A licensed limited lines travel insurance producer must designate one employee responsible for compliance issues applicable to the licensee and the registered travel retailers appointed under the licensee. The licensed producer must provide for the training of all employees and appointees. The licensed producer is responsible for all acts of its appointees and must ensure compliance with the law.

The bill gives DFS rulemaking authority to administer the chapter.

Surplus Lines Agent Affidavits

Background

SURPLUS LINES OVERVIEW

Surplus lines insurance refers to a category of insurance for risks that the admitted market is unable or unwilling to provide coverage.[37] There are three basic categories of surplus lines risks:

- Specialty risks that have unusual underwriting characteristics or underwriting characteristics that admitted insurers view as undesirable;
- Niche risks for which admitted carriers do not have a filed policy form or rate; and
- Capacity risks that are risks where an insured needs higher coverage limits than those that are available in the admitted market.

Surplus lines insurers are not "authorized" insurers as defined in the Florida Insurance Code, which means they do not obtain a certificate of authority from OIR to transact insurance in Florida.[38] Rather, surplus lines insurers are "unauthorized" insurers[39] that may transact surplus lines insurance, if they are made eligible by OIR.

The Florida Surplus Lines Service Office (FSLSO) is a self-regulating, nonprofit association of approved unauthorized insurers established by the Legislature in 1997. The FSLSO was created to protect consumers seeking surplus line insurance in the state, monitor marketplace compliance, and protect state revenues.[40] All licensed surplus lines agents are deemed to be members of the FSLSO. The FSLSO operates under the supervision of a nine-member board of governors, which has oversight responsibilities for the Florida surplus lines market.

"To export" a policy[41] means to place it with an unauthorized insurer under the Surplus Lines Law.[42] Unless an exception applies, the insurance agent must make a diligent effort to procure the desired coverage from admitted insurers before the agent can place insurance in the surplus lines market.[43]

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[37] The admitted market is comprised of insurance companies licensed to transact insurance in Florida. The administration of surplus lines insurance business is managed by the Florida Surplus Lines Service Office. S. 626.921, F.S.
[38] S. 624.09(1), F.S.
[39] S. 624.09(2), F.S.
[40] See S. 626.921, F.S. and FLORIDA SURPLUS LINES SERVICE OFFICE, *About*, https://www.fslso.com/about (last visited Jan. 26, 2020).
[41] S. 626.914(3), F.S.
[42] Sections 626.913 – 626.937, F.S., constitute the "Surplus Lines Law." S. 626.913(1), F.S.
[43] S. 626.916(1)(a), F.S.

"Diligent effort" means, subject to certain exceptions,[44] seeking coverage from and being rejected by at least three authorized insurers in the admitted market.[45] The law further specifies that:[46]

- The premium rate for policies written by a surplus lines insurer cannot be less than the premium rate used by a majority of authorized insurers for the same coverage on similar risks;
- The policy exported cannot provide coverage or rates that are more favorable than those that are used by the majority of authorized insurers actually writing similar coverages on similar risks;
- The deductibles must be the same as those used by one or more authorized insurers, unless the coverage is for fire or windstorm; and
- For personal residential property risks,[47] the policyholder must be advised in writing that coverage may be available and less expensive from Citizens Property Insurance Corporation (Citizens).

SURPLUS LINES AGENTS

Surplus lines agents are authorized to handle the placement of insurance coverages with surplus lines insurers.[48] Licensed resident general lines agents who meet the statutory criteria for licensure are eligible for licensure as a surplus lines agent.[49] In order to place coverage with a surplus lines carrier, the agent must make a "diligent effort" to place the policy with a Florida-authorized insurer, i.e., one with a certificate of authority from OIR.[50]

Surplus lines agents are required to report and file with the FSLSO specified information on each surplus lines insurance policy within 30 days of the effective date of the transaction, must transmit service fees to the FSLSO each month, and must transmit assessment and tax payments to the FSLSO quarterly.[51] When requested by DFS or the FSLSO, surplus lines agents are also required to submit a copy of any policy and certain other information.[52] Surplus lines agents are required to maintain each surplus lines contract, including applications and all certificates, and other detailed information about each surplus lines policy, in their agency office for a period of five years.[53]

Effect of the Bill

The bill eliminates the required quarterly affidavit. The FSLSO receives relevant information electronically in ongoing data filings.

Workers' Compensation Insurance Reporting Requirements

Background

Workers' compensation insurance carriers are required to record and report certain loss, expense, and claims experience to aid OIR in making determinations concerning the adequacy of workers'

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[44] Exceptions include commercial lines risk, such as "excess or umbrella, surety and fidelity, boiler and machinery and leakage and fire extinguishing equipment," and so on, as specified in s. 627.062(3)(d)1., F.S. S. 626.916(3)(b), F.S.
[45] If the cost to replace a residential dwelling is $1,000,000 or more, then only one coverage rejection is needed prior to export. S. 626.914(4), F.S. When exporting a flood insurance policy, diligent effort requirements do not apply until July 1, 2019, or the Insurance Commissioner declares an adequate flood insurance market among admitted insurers, whichever occurs first. S. 627.715(4), F.S.
[46] S. 626.916(1), F.S.
[47] Personal residential policies include homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners, and similar policies.
[48] S. 626.914(1), F.S.
[49] S. 626.927, F.S. Generally, to be licensed as a surplus lines agent, an individual must be: (1) deemed DFS to have sufficient experience in the insurance business (2) have 1-year experience working for a licensed surplus lines agent or have completed 60 class hours in an approved surplus lines course, and (3) pass a written examination.
[50] There are certain exceptions to the diligent effort requirement. *Supra*, note 44.
[51] Ss. 626.921(2) and 626.931, F.S.
[52] S. 626.923, F.S.
[53] S. 626.930, F.S.

compensation experience for ratemaking purposes.[54] Additionally, carriers are required to provide the following information annually on both Florida experience and nationwide experience separately:

- Payrolls by classification;
- Manual premiums by classification;
- Standard premiums by classification;
- Losses by classification and injury type; and
- Expenses.

Carriers satisfy these requirements by providing their data to the National Council on Compensation Insurance, Inc. (NCCI). When a carrier goes into receivership due to insolvency, they cease reporting to NCCI and, therefore, their data is no longer reported to OIR.

Effect of the Bill

The bill requires workers' compensation carriers that enter receivership to continue to report the required data. The receiver, who is now in possession of the carrier, is permitted to do so directly or outsource the reporting to a third party. OIR may approve a modified reporting plan to accommodate limited data reporting.

Agent Licensing

Background

GENERAL LINES AGENT

A general lines agent[55] is one who sells the following lines of insurance: property;[56] casualty,[57] including commercial liability insurance underwritten by a risk retention group, a commercial self-insurance fund,[58] or a workers' compensation self-insurance fund;[59] surety;[60] health;[61] and marine.[62] The general lines agent may only transact health insurance for an insurer that the general lines agent also represents for property and casualty insurance. If the general lines agent wishes to represent health insurers that are not also property and casualty insurers, they must be licensed as a health insurance agent.[63]

PERSONAL LINES AGENT

A personal lines agent is a general lines agent who is limited to transacting business related to property and casualty insurance sold to individuals and families for noncommercial purposes.[64]

MOTOR VEHICLE SERVICING AGREEMENTS

Motor vehicle service agreements provide vehicle owners with protection when the manufacturer's warranty expires. A motor vehicle service agreement indemnifies the vehicle owner (or holder of the agreement) against loss caused by failure of any mechanical or other component part, or any mechanical or other component part that does not function as it was originally intended. Motor vehicle service agreements can only be sold by a licensed and appointed salesperson. Salespersons are

[54] S. 627.914, F.S. *See also* R. 69O-189.0055, F.A.C.
[55] S. 626.015(5), F.S.
[56] S. 624.604, F.S.
[57] S. 624.605, F.S.
[58] As defined in s. 624.462, F.S.
[59] Pursuant to s. 624.4621, F.S.
[60] S. 626.606, F.S.
[61] Ss. 624.603 and 627.6482, F.S.
[62] S. 624.607, F.S.
[63] S. 626.829, F.S.
[64] S. 626.015(17), F.S.

licensed in the same manner as insurance representatives under chapter 626, F.S., with some exceptions to the requirements applied to insurance representatives.

SERVICE WARRANTY ASSOCIATIONS

Service warranty associations are entities, other than insurers, which issue service warranties. A service warranty is an agreement or maintenance service contract equal to or greater than 1 year in length to repair, replace, or maintain a consumer product, or for indemnification for repair, replacement, or maintenance, for operational or structural failure due to a defect in materials or workmanship, normal wear and tear, power surge, or accidental damage from handling in return for the payment of a segregated charge by the consumer.[65] No person or entity shall solicit, negotiate, advertise, or effectuate service warranty contracts in this state unless such person or entity is licensed and appointed as a sales representative.[66]

HOME WARRANTY CONTRACTS

A home warranty association is any corporation or any other organization, other than an authorized insurer, issuing home warranties. A home warranty is any contract or agreement whereby a person undertakes to indemnify the warranty holder against the cost of repair or replacement, or actually furnishes repair or replacement, of any structural component or appliance of a home, necessitated by wear and tear or an inherent defect of any such structural component or appliance or necessitated by the failure of an inspection to detect the likelihood of any such loss. No person may solicit, negotiate, or effectuate home warranty contracts for remuneration in this state unless such person is licensed and appointed as a sales representative.[67]

Effect of the Bill

The bill allows a licensed general lines agent or licensed personal lines agent to advertise, solicit, negotiate, or sell motor vehicle service agreements, home warranty contracts, or service warranty contracts without being separately licensed as a sales representative or insurance representative, as applicable.[68]

B. SECTION DIRECTORY:

Section 1. Amending s. 215.555, F.S., relating to Florida Hurricane Catastrophe Fund.
Section 2. Amending s. 316.646, F.S., relating to security required; proof of security and display thereof.
Section 3. Amending s. 320.02, F.S., relating to registration required; application for registration; forms.
Section 4. Creating s. 324.252, F.S., relating to insurance online verification system.
Section 5. Creating s. 324.255, F.S., relating to Motor Vehicle Insurance Online Verification Task Force.
Section 6. Amending s. 624.01, F.S., relating to short title.
Section 7. Amending s. 626.321, F.S., relating to limited licenses.
Section 8. Amending s. 626.931, F.S., relating to agent affidavit and Insurer reporting requirements.
Section 9. Amending s. 626.932, F.S., relating to surplus lines tax.
Section 10. Amending s. 626.935, F.S., relating to suspension, revocation, or refusal of surplus lines agent's license.
Section 11. Amending s. 627.7295, F.S., relating to motor vehicle insurance contracts.

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[65] S. 634.401(13).
[66] S. 634.419, F.S. A "sales representative" is any person, retail store, corporation, partnership, or sole proprietorship utilized by an insurer or service warranty association for the purpose of selling or issuing service warranties. However, in the case of service warranty associations selling service warranties from one or more business locations, the person in charge of each location may be considered the sales representative. S. 634.401(12), F.S.
[67] S. 634.317, F.S. "Sales representative" is any person with whom an insurer or home inspection or warranty association has a contract and who is utilized by such insurer or association for the purpose of selling or issuing home warranties. The term includes all employees of an insurer or association engaged directly in the sale or issuance of home warranties. S. 634.301(12), F.S.
[68] See Section III.C., Drafting Issues or Other Comments.

Section 12. Amending s. 627.914, F.S., relating to reports of information by workers' compensation insurers required.
Section 13. Amending s. 634.171, F.S., relating to salesperson to be licensed and appointed.
Section 14. Amending s. 634.317, F.S., relating to license and appointment required.
Section 15. Amending s. 634.419, F.S., relating to license and appointment required.
Section 16. Providing direction to the Division of Law Revision.
Section 17. Creating s. 647.01, F.S., relating to purpose and scope.
Section 18. Creating s. 647.02, F.S., relating to definitions.
Section 19. Creating s. 647.03, F.S., relating to premium tax.
Section 20. Creating s. 647.04, F.S., relating to travel protection plans.
Section 21. Creating s. 647.05, F.S., relating to sales practices.
Section 22. Creating s. 647.06, F.S., relating to travel administrators.
Section 23. Creating s. 647.07, F.S., relating to travel insurance policy.
Section 24. Creating s. 647.08, F.S., relating to rulemaking authority.
Section 25. Provides for when select sections of the bill become effective.
Section 26. Providing an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The licenses and appointments for representation of travel insurers are subject to filing and renewal fees. Some entities may no longer be required to obtain licensure under the bill. However, these entities will still be required to pay appointment fees. There are few licensees in travel insurance, but many appointees. This may result in an insignificant reduction in revenue.

The implementation of the online insurance verification system may result in a positive, but indeterminate, revenue increase in the fiscal years immediately following the rollout of the system. The revenue increase would be a result of uninsured motorist becoming compliant and the payment of financial responsibility fines. Once the system is established, a negative but indeterminate revenue decrease may occur as the number of uninsured motorists decreases. [69]

2. Expenditures:

The bill requires DHSMV to implement an online insurance verification system; however, implementation is contingent upon a specific appropriation. Based upon site visits and vendor demonstrations, the DHSMV estimates that implementation costs of a basic vendor-supplied system will require a minimum appropriation of $3.3 million. The cost to operate the system is estimated to range from $2.8 to $3.4 million in the out years following implementation.[70] The bill also requires DHSMV to implement a disaster recovery plan to ensure continuous service in the event of a disaster; however, the cost of disaster recovery service is unknown at this time. DHSMV anticipates training costs and minimal expenditures to update policies and procedures which can be absorbed within existing resources.

DFS estimates that there would be significant costs related to reconfiguring policy and claims systems to capture the required data for continued reporting for workers' compensation carriers that enter receivership. DFS estimates these costs to be $500,000 or more.[71]

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[69] Department of Highway Safety and Motor Vehicles, Agency Analysis of 2020 House Bill 895, p. 7-9 (December 11, 2019).
[70] *Id.*
[71] Email from Meredith Stanfield, Director of Legislative and Cabinet Affairs, Department of Financial Services, (Feb. 14, 2020).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to DHSMV, the provision that requires all licensed insurers in Florida to transmit motor vehicle insurance policy status information to the department on a weekly basis, may likely have a significant impact on smaller companies.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Article VII, s. 19, Florida Constitution, does not appear to apply. Travel insurance is currently subject to premium tax under the Florida Insurance Code. The newly created chapter 647, F.S., Travel Insurance, includes a premium tax provision regarding travel insurance likely to prevent currently taxable premiums from being relieved of the tax.

B. RULE-MAKING AUTHORITY:

The bill requires DFS to adopt rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 21 of the bill creates two new violations of the Unfair Insurance Trade Practices Act in relation to travel insurance. It may avoid confusion if these provision were amended into the Act, rather than stating them in a separate chapter of statute.

Section 21 of the bill cross-references s. 626.321 (1)(c)3.a., F.S., in regard to information that must be disclosed to a policyholder or certificate holder. The effect of this cross reference is unclear.

Section 22 of the bill exempts a travel administrator and its employees from the licensing requirements in chapter 626, part VI, F.S. Currently, there are express exemptions listed in statute.[72] It may avoid confusion if the bill's exemptions are placed with the existing exemptions found in s. 626.852, F.S.

[72] Ss. 626.852(3)-(6), F.S.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Insurance & Banking Subcommittee considered a proposed committee substitute, adopted two amendments, and reported the bill favorably as a committee substitute. The following changes were made to the bill:

- **Deletions**
  - Removed two sections of the bill (ss. 6 and 25) that proposed to create certain requirements for disposition of insurance proceeds.

- **Additions:**
  - Added a new section to the bill (s. 25) to include chapter. 647, F.S., within the Florida Insurance Code. This clarifies that the regulation of travel insurance will continue to be done within the Code.

- **Revisions:**
  - Motor Vehicle Insurance Online Verification System –
    - Incorporated technical and clarifying changes identified by the Department of Highway Safety & Motor Vehicles; and
    - Made the development and implementation of the Motor Vehicle Insurance Online Verification System and the associated task force contingent upon receiving a specific appropriation, which could occur this Session or in the future.
  - Travel Insurance – made several revisions to conform the travel insurance related portions of the bill to the structure of the Florida Insurance Code.

The staff analysis has been updated to reflect the committee substitute.

A bill to be entitled

An act relating to insurance; amending s. 215.555, F.S.; revising the definition of the term "covered policy" to include a coverage amount requested by lenders under specified residential insurance policies in certain circumstances; amending s. 316.646, F.S.; requiring law enforcement officers to access certain information during traffic stops or crash investigations for certain purposes; amending s. 320.02, F.S.; authorizing insurance online verification for motor vehicle registration; creating s. 324.252, F.S.; requiring the Department of Highway Safety and Motor Vehicles to establish an online verification system for motor vehicle insurance; providing system requirements; providing powers and duties of the department; providing requirements for insurers and law enforcement officers; providing immunity from liability; prohibiting the use of an online verification request or response for a civil action; providing applicability; providing rulemaking authority; creating s. 324.255, F.S.; creating the Motor Vehicle Insurance Online Verification Task Force; providing duties of the task force; providing membership; providing meeting requirements; requiring the department to provide support; providing report

requirements; providing the date by which the task force must complete its work and submit its final report; providing for expiration of the task force; amending s. 624.01, F.S.; adding ch. 647, F.S., to the list of statutes composing the Florida Insurance Code; amending s. 626.321, F.S.; revising the list of individuals and entities who may apply for licenses to transact a limited class of business in specified categories of limited lines insurance; revising the requirements for such licenses; prohibiting persons from engaging in certain acts unless licensed or registered; providing authorizations and duties of limited lines travel insurance producers and travel retailers; requiring travel retailer registers; providing applicability of penalties; providing fingerprinting requirements and licensing and appointment fee requirements; providing instruction or training requirements under certain circumstances; authorizing travel retailers to receive compensation under certain circumstances; providing that limited lines travel insurance producers are responsible for their travel retailers' acts; authorizing persons licensed as general lines or personal lines insurance agents to sell, solicit, and negotiate travel insurance; amending s. 626.931, F.S.; deleting

provisions requiring certain surplus lines agents to file affidavits with the Florida Surplus Lines Service Office; amending s. 626.932, F.S.; revising the timeline for the surplus lines agents' tax remittance; amending s. 626.935, F.S.; conforming provisions to changes made by the act; amending s. 627.7295, F.S.; revising the timeframe for insurers' cancellation of motor vehicle insurance policies or contracts for nonpayment; amending s. 627.914, F.S.; requiring certain workers' compensation insurers and self-insurance funds to continue to report certain information; authorizing such reporting to be outsourced under certain circumstances; requiring the office to approve a modified reporting plan; authorizing the office to use certain information for a specified purpose; amending ss. 634.171, 634.317, and 634.419, F.S.; authorizing licensed personal lines or general lines agents to advertise, solicit, negotiate, or sell motor vehicle service agreements, home warranties, and service warranties, respectively, without a salesperson or sales representative license; providing a directive to the Division of Law Revision; creating s. 647.01, F.S.; providing purpose; providing applicability; creating s. 647.02, F.S.; providing definitions; creating s. 647.03, F.S.; providing

definitions; providing requirements for certain travel insurance premiums for tax purposes; providing duties of travel insurers; creating s. 647.04, F.S.; authorizing travel protection plans to be offered under certain circumstances; creating s. 647.05, F.S.; providing requirements for documents provided to consumers before the purchase of travel insurance; providing requirements for disclosures of preexisting condition exclusions in travel insurance policies and certificates; providing requirements for fulfillment materials and specified information; providing circumstances under which travel protection plan payments may be cancelled for a full refund; providing practices that are not unfair trade practices or violations of law; prohibiting certain practices; providing that persons offering travel insurance to residents of this state are subject to the Unfair Insurance Trade Practices Act; providing that specified provisions supersede such act; providing practices that are unfair insurance trade practices; creating s. 647.06, F.S.; prohibiting certain persons from representing themselves as travel administrators; exempting travel administrators and their employees from certain licensing requirements; providing insurers' responsibilities relating to travel

administrators; creating s. 647.07, F.S.; providing classification and filing of travel insurance for purposes of rates and forms; authorizing travel insurance programs to be developed and provided based on specified travel protection plans; creating s. 647.08, F.S.; requiring the Department of Financial Services to adopt rules; providing contingent effect; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 215.555, Florida Statutes, is amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(2) DEFINITIONS.—As used in this section:

(c) "Covered policy" means any insurance policy covering residential property in this state, including, but not limited to, any homeowner, mobile home owner, farm owner, condominium association, condominium unit owner, tenant, or apartment building policy, or any other policy covering a residential structure or its contents issued by any authorized insurer, including a commercial self-insurance fund holding a certificate of authority issued by the Office of Insurance Regulation under s. 624.462, the Citizens Property Insurance Corporation, and any joint underwriting association or similar entity created under

law. The term "covered policy" includes any collateral protection insurance policy covering personal residences which protects both the borrower's and the lender's financial interests, in an amount at least equal to the coverage for the dwelling in place under the lapsed homeowner's policy, or in an amount at least equal to the coverage amount requested by the lender if the homeowner has been notified in writing of the coverage amount and the homeowner has not requested that the insurer issue the policy in a different amount, if such policy can be accurately reported as required in subsection (5). Additionally, covered policies include policies covering the peril of wind removed from the Florida Residential Property and Casualty Joint Underwriting Association or from the Citizens Property Insurance Corporation, created under s. 627.351(6), or from the Florida Windstorm Underwriting Association, created under s. 627.351(2), by an authorized insurer under the terms and conditions of an executed assumption agreement between the authorized insurer and such association or Citizens Property Insurance Corporation. Each assumption agreement between the association and such authorized insurer or Citizens Property Insurance Corporation must be approved by the Office of Insurance Regulation before the effective date of the assumption, and the Office of Insurance Regulation must provide written notification to the board within 15 working days after such approval. "Covered policy" does not include any policy that

excludes wind coverage or hurricane coverage or any reinsurance agreement and does not include any policy otherwise meeting this definition which is issued by a surplus lines insurer or a reinsurer. All commercial residential excess policies and all deductible buy-back policies that, based on sound actuarial principles, require individual ratemaking shall be excluded by rule if the actuarial soundness of the fund is not jeopardized. For this purpose, the term "excess policy" means a policy that provides insurance protection for large commercial property risks and that provides a layer of coverage above a primary layer insured by another insurer.

Section 2. Subsection (5) of section 316.646, Florida Statutes, is renumbered as subsection (6), and a new subsection (5) is added to that section, to read:

316.646 Security required; proof of security and display thereof.—

(5) Eighteen months after implementation of the motor vehicle insurance online verification system established in s. 324.252, a law enforcement officer, during a traffic stop or crash investigation, shall access information from the online verification system to establish compliance with this chapter and chapter 324.

Section 3. Paragraph (f) is added to subsection (5) of section 320.02, Florida Statutes, to read:

320.02 Registration required; application for

registration; forms.—

(5)

(f) Upon implementation of the motor vehicle insurance online verification system established in s. 324.252, the online verification may be used in lieu of the verification procedures in this subsection.

Section 4. Section 324.252, Florida Statutes, is created to read:

324.252 Insurance online verification system.—The department shall establish an online verification system for motor vehicle insurance. The goal of the system is to identify uninsured motorists and aid the department in the enforcement of the financial responsibility law.

(1) The online verification system must:

(a) Be accessible through electronic means for use by any government agency, including any court or law enforcement agency, in carrying out its functions; any private person or entity acting on behalf of a federal, state, or local agency in carrying out its functions; any other entity authorized by the department; and any insurer authorized by the Office of Insurance Regulation to provide motor vehicle insurance. The department may also establish a web portal or other mechanism that provides the general public with the ability to confirm whether a particular motor vehicle is currently insured.

(b) In real time, send requests to insurers for

verification of evidence of insurance for motor vehicles registered in this state, and receive confirmation in real time from insurers via electronic means consistent with the specifications and standards of the Insurance Industry Committee on Motor Vehicle Administration (IICMVA), with enhancements, additions, and modifications as required by the department. However, the enhancements, additions, and modifications may not conflict with, nullify, or add requirements that are materially inconsistent with the specifications or standards of the IICMVA.

(c) Be operational within 3 years after this section becomes effective. The Motor Vehicle Insurance Online Verification Task Force established in s. 324.255 must conduct a pilot program for at least 9 months to test the system before statewide use. The system may not be used in any enforcement action until successful completion of the pilot program.

(d) Be available 24 hours a day, except as provided in paragraph (2)(a), to verify the insurance status of any vehicle registered in this state through the insurer's National Association of Insurance Commissioners (NAIC) company code or Florida company code in combination with other identifiers, including vehicle identification number, car make, car model, year, registered owner's name, policy number, levels or types of coverage, or other characteristics or markers as specified by the Motor Vehicle Insurance Online Verification Task Force.

(e) Include appropriate safeguards and controls to prevent

misuse or unauthorized access.

(f) Include a disaster recovery plan to ensure service continuity in the event of a disaster.

(g) Include information that enables the department to make inquiries of evidence of insurance by using multiple data elements for greater matching accuracy, specifically the insurer's NAIC company code, in combination with other identifiers such as vehicle identification number, policy number, or other characteristics or markers as specified by the Motor Vehicle Insurance Online Verification Task Force or the department.

(h) Include a self-reporting mechanism for insurers with fewer than 2,000 vehicles insured within this state or for individual entities that are self-insured.

(2) The department has the following powers and duties:

(a) Upon an insurer's advance notice to the department, the department shall allow online services established by the insurer to have reasonable downtime for system maintenance and other work, as needed. An insurer is not subject to administrative penalties or disciplinary actions when its online services are not available under such circumstances or when an outage is unplanned by the insurer and is reasonably outside its control.

(b) Upon recommendation of the Motor Vehicle Insurance Online Verification Task Force, the department may develop and

operate its own system or competitively procure a private vendor that has personnel with extensive operational and management experience in the development, deployment, and operation of insurance online verification systems.

(c) The department and its private vendor, if any, shall each maintain a contact person for the insurers during the establishment, implementation, and operation of the system.

(d) The department may enter into agreements governing the use of the system with any public or private entity accessing the system to verify insurance coverage.

(e) The department shall maintain a historical record of the system data for 3 years after the date of any verification request and response.

(3) An insurance company authorized to issue insurance policies for motor vehicles registered in this state:

(a) Shall comply with the verification requirements of motor vehicle insurance for every motor vehicle insured by that company in this state.

(b) Shall maintain policyholder records in order to confirm insurance coverage for 3 years after the date of any verification request and response.

(c) Shall cooperate with the department in establishing, implementing, and maintaining the system.

(d) Is immune from civil liability for good faith efforts to comply with this section. An online verification request or

response may not be used as the basis of a civil action against an insurer.

(4) A law enforcement officer, during a traffic stop or crash investigation, shall query information from the online verification system to establish compliance with this chapter.

(5) This section does not apply to vehicles insured under commercial motor vehicle coverage. As used in this subsection, the term "commercial motor vehicle coverage" means any coverage provided to an insured under a commercial coverage form and rated from a commercial manual approved by the Office of Insurance Regulation. However, insurers of such vehicles may participate in the online verification system on a voluntary basis.

(6) The department may adopt rules to administer this section.

Section 5. Section 324.255, Florida Statutes, is created to read:

324.255 Motor Vehicle Insurance Online Verification Task Force.—There is created the Motor Vehicle Insurance Online Verification Task Force within the department.

(1) The task force shall:

(a) Facilitate the implementation of the motor vehicle insurance online verification system established in s. 324.252.

(b) Assist in the development of a detailed guide for insurers by providing data fields and other information

necessary for compliance with the online verification system.

(c) Coordinate a pilot program and conduct the program for at least 9 months to test the online verification system and identify necessary changes to be implemented before statewide use.

(d) Issue recommendations based on periodic reviews of the online verification system.

(2) The task force shall consist of 10 voting members and one nonvoting member.

(a) By July 31 of the year this section becomes effective, the 10 voting members shall be appointed in the following manner:

1. Three representatives of the department, representing the Florida Highway Patrol, the Division of Motorist Services, and the Information Systems Administration, appointed by the executive director of the department.

2. One representative of the Office of Insurance Regulation, appointed by the Commissioner of Insurance.

3. Three representatives of the motor vehicle insurance industry, appointed by the Chief Financial Officer as follows:

a. One member must represent the motor vehicle insurer with the largest national market share as of December 31 of the year prior to the appointment.

b. One member must represent the motor vehicle insurer with the largest Florida market share as of December 31 of the

year prior to the appointment.

c. One member must be selected from a list of representatives recommended by the Insurance Industry Committee on Motor Vehicle Administration.

4. One representative of the Department of Financial Services, appointed by the Chief Financial Officer.

5. One representative of the Division of State Technology, appointed by the secretary of the Department of Management Services.

6. One member who must be a member of local law enforcement, appointed by the executive director of the department.

(b) The executive director of the department, who shall be a nonvoting member, shall serve as chair of the task force.

(3) By September 30 of the year this section becomes effective, the task force shall meet to establish procedures for the conduct of its business, and the voting members shall elect a vice chair at that meeting. The task force shall meet at the call of the chair, who shall prepare the agenda for each meeting with the consent of the task force. A majority of the voting members of the task force constitutes a quorum, and a quorum is necessary for the purpose of voting on any action or recommendation of the task force. All meetings shall be held in Tallahassee.

(4) The department shall provide the task force members

with administrative and technical support. Task force members shall serve without compensation and are not entitled to reimbursement for per diem or travel expenses.

(5) By July 1 of the third year after this section becomes effective, the task force shall complete its work and submit its final report evaluating the online verification system's effectiveness and making recommendations for system enhancements to the department, the President of the Senate, and the Speaker of the House of Representatives. Upon submission of the report, the task force shall expire.

Section 6. Section 624.01, Florida Statutes, is amended to read:

624.01 Short title.—Chapters 624-632, 634, 635, 636, 641, 642, 647, 648, and 651 constitute the "Florida Insurance Code."

Section 7. Paragraph (c) of subsection (1) of section 626.321, Florida Statutes, is amended to read:

626.321 Limited licenses and registration.—

(1) The department shall issue to a qualified applicant a license as agent authorized to transact a limited class of business in any of the following categories of limited lines insurance:

(c) Travel insurance.—License covering only policies and certificates of travel insurance which are subject to review by the office. Policies and certificates of travel insurance may provide coverage for travel insurance, as defined in s. 647.02

~~risks incidental to travel, planned travel, or accommodations while traveling, including, but not limited to, accidental death and dismemberment of a traveler; trip or event cancellation, interruption, or delay; loss of or damage to personal effects or travel documents; damages to travel accommodations; baggage delay; emergency medical travel or evacuation of a traveler; or medical, surgical, and hospital expenses related to an illness or emergency of a traveler. Such policy or certificate may be issued for terms longer than 90 days, but, other than a policy or certificate providing coverage for air ambulatory services only, each policy or certificate must be limited to coverage for travel or use of accommodations of no longer than 90 days~~. The license may be issued only to an individual or business entity that has filed with the department an application for a license in a form and manner prescribed by the department.~~:~~

1. A limited lines travel insurance producer, as defined s. 647.02, shall be licensed to sell, solicit, or negotiate travel insurance through a licensed insurer.

2. A person may not act as a limited lines travel insurance producer or travel retailer unless properly licensed or registered, respectively. As used in this paragraph, the term "travel retailer" means a business entity that:

a. Makes, arranges, or offers planned travel.

b. May, under subparagraph 3., offer and disseminate travel insurance as a service to its customers on behalf of and

under the direction of a limited lines travel insurance producer.

3. A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if all of the following requirements are met:

a. The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage.

(II) A description of the process for filing a claim.

(III) A description of the review or cancellation process for the travel insurance policy.

(IV) The identity and contact information of the insurer and limited lines travel insurance producer.

b. At the time of licensure, the limited lines travel insurance producer establishes and maintains a register on the department's website and appoints each travel retailer that offers travel insurance on behalf of the limited lines travel insurance producer. The limited lines travel insurance producer must maintain and update the register, which must include the travel retailer's federal tax identification number and the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations. The limited lines travel insurance

producer shall submit the register to the department upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer register complies with 18 U.S.C s. 1033. The grounds for the suspension and revocation and the penalties applicable to resident insurance producers under this section apply to the limited lines travel insurance producers and travel retailers.

c. The limited lines travel insurance producer has designated one of its employees as the designated responsible producer. The designated responsible producer, who must be a licensed insurance producer, is responsible for the compliance with the travel insurance laws and regulations applicable to the limited lines travel insurance producer and its registrants. The designated responsible producer and the president, secretary, treasurer, and any other officer or person who direct or control the limited lines travel insurance producer's insurance operations must comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer.

d. The limited lines travel insurance producer has paid all applicable licensing and appointment fees as set forth in applicable general law.

e. The limited lines travel insurance producer requires each employee and each authorized representative of the travel retailer whose duties include offering and disseminating travel

insurance to receive a program of instruction or training, which is subject, at the discretion of the department, to review and approval. The training material must, at a minimum, contain adequate instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective purchasers.

As used in this paragraph, the term "offer and disseminate" means to provide general information, including a description of the coverage and price, as well as processing the application and collecting premiums.

4. A travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the travel insurer. Such materials must include information that, at a minimum:

a. Provides the identity and contact information of the insurer and the limited lines travel insurance producer.

b. Explains that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer.

c. Explains that a travel retailer is authorized to provide only general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical

questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

5. A travel retailer employee or authorized representative who is not licensed as an insurance producer may not:

a. Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

b. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

c. Hold himself or herself or the travel retailer out as a licensed insurer, licensed producer, or insurance expert.

Notwithstanding any other provision of law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions in this section may receive related compensation upon registration by the limited lines travel insurance producer as described in paragraph (2)(b).

6. As the insurer's designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this section.

7. Any person licensed as a general lines or personal

lines insurance agent may sell, solicit, and negotiate travel insurance.

~~1. To a full-time salaried employee of a common carrier or a full-time salaried employee or owner of a transportation ticket agency and may authorize the sale of such ticket policies only in connection with the sale of transportation tickets, or to the full-time salaried employee of such an agent. Such policy may not be for more than 48 hours or more than the duration of a specified one-way trip or round trip.~~

~~2. To an entity or individual that is:~~

~~a. The developer of a timeshare plan that is the subject of an approved public offering statement under chapter 721;~~

~~b. An exchange company operating an exchange program approved under chapter 721;~~

~~c. A managing entity operating a timeshare plan approved under chapter 721;~~

~~d. A seller of travel as defined in chapter 559; or~~

~~e. A subsidiary or affiliate of any of the entities described in sub-subparagraphs a.-d.~~

~~3. To a full-time salaried employee of a licensed general lines agent or a business entity that offers travel planning services if insurance sales activities authorized by the license are in connection with, and incidental to, travel.~~

~~a. A license issued to a business entity that offers travel planning services must encompass each office, branch~~

~~office, or place of business making use of the entity's business name in order to offer, solicit, and sell insurance pursuant to this paragraph.~~

~~b. The application for licensure must list the name, address, and phone number for each office, branch office, or place of business that is to be covered by the license. The licensee shall notify the department of the name, address, and phone number of any new location that is to be covered by the license before the new office, branch office, or place of business engages in the sale of insurance pursuant to this paragraph. The licensee shall notify the department within 30 days after the closing or terminating of an office, branch office, or place of business. Upon receipt of the notice, the department shall delete the office, branch office, or place of business from the license.~~

~~c. A licensed and appointed entity is directly responsible and accountable for all acts of the licensee's employees and parties with whom the licensee has entered into a contractual agreement to offer travel insurance.~~

~~A licensee shall require each individual who offers policies or certificates under subparagraph 2. or subparagraph 3. to receive initial training from a general lines agent or an insurer authorized under chapter 624 to transact insurance within this state. For an entity applying for a license as a travel~~

~~insurance agent, the fingerprinting requirement of this section applies only to the president, secretary, and treasurer and to any other officer or person who directs or controls the travel insurance operations of the entity.~~

Section 8. Section 626.931, Florida Statutes, is amended to read:

626.931 ~~Agent affidavit and~~ Insurer reporting requirements.—

~~(1) Each surplus lines agent that has transacted business during a calendar quarter shall on or before the 45th day following the calendar quarter file with the Florida Surplus Lines Service Office an affidavit, on forms as prescribed and furnished by the Florida Surplus Lines Service Office, stating that all surplus lines insurance transacted by him or her during such calendar quarter has been submitted to the Florida Surplus Lines Service Office as required.~~

~~(2) The affidavit of the surplus lines agent shall include efforts made to place coverages with authorized insurers and the results thereof.~~

(1)~~(3)~~ Each foreign insurer accepting premiums shall, on or before the end of the month following each calendar quarter, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during such calendar quarter.

(2)~~(4)~~ Each alien insurer accepting premiums shall, on or before June 30 of each year, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during the preceding calendar year.

(3)~~(5)~~ The department may waive the filing requirements described in subsections (1) ~~(3)~~ and (2) ~~(4)~~.

(4)~~(6)~~ Each insurer's report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on forms prescribed by the Florida Surplus Lines Service Office and shall show for each applicable agent:

(a) A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number; and

(b) Any additional information required by the department or Florida Surplus Lines Service Office.

Section 9. Paragraph (a) of subsection (2) of section 626.932, Florida Statutes, is amended to read:

626.932 Surplus lines tax.—

(2)(a) The surplus lines agent shall make payable to the department the tax related to each calendar quarter's business as reported to the Florida Surplus Lines Service Office, and remit the tax to the Florida Surplus Lines Service Office at the

same time as the fee payment required ~~provided for the filing of the quarterly affidavit,~~ under s. 626.9325 ~~s. 626.931~~. The Florida Surplus Lines Service Office shall forward to the department the taxes and any interest collected pursuant to paragraph (b), within 10 days of receipt.

Section 10. Paragraph (d) of subsection (1) of section 626.935, Florida Statutes, is amended to read:

626.935 Suspension, revocation, or refusal of surplus lines agent's license.—

(1) The department shall deny an application for, suspend, revoke, or refuse to renew the appointment of a surplus lines agent and all other licenses and appointments held by the licensee under this code, on any of the following grounds:

~~(d) Failure to make and file his or her affidavit or reports when due as required by s. 626.931.~~

Section 11. Subsection (4) of section 627.7295, Florida Statutes, is amended to read:

627.7295 Motor vehicle insurance contracts.—

(4) The insurer may cancel the policy in accordance with this code except that, notwithstanding s. 627.728, an insurer may not cancel a new policy or binder during the first 30 ~~60~~ days immediately following the effective date of the policy or binder for nonpayment of premium unless the reason for the cancellation is the issuance of a check for the premium that is dishonored for any reason or any other type of premium payment

that was subsequently determined to be rejected or invalid.

Section 12. Subsection (4) of section 627.914, Florida Statutes, is renumbered as subsection (5), subsections (2) and (3) of that section are amended, and a new subsection (4) is added to that section, to read:

627.914 Reports of information by workers' compensation insurers required.—

(2)(a) Each insurer and self-insurance fund authorized to write a policy of workers' compensation insurance shall report ~~transmit~~ the following information annually on both Florida experience and nationwide experience separately:

1.~~(a)~~ Payrolls by classification.

2.~~(b)~~ Manual premiums by classification.

3.~~(c)~~ Standard premiums by classification.

4.~~(d)~~ Losses by classification and injury type.

5.~~(e)~~ Expenses.

An insurer or self-insurance fund that is placed in receivership pursuant to part I of chapter 631 must continue to report the information required under this paragraph. At the discretion of the receiver, the insurer or self-insurance fund may outsource the reporting of such information to a third-party reporting vendor. The office shall approve a modified reporting plan that is limited in terms of data elements.

(b) A report of the ~~this~~ information required under

paragraph (a) shall be filed no later than July 1 of each year. All reports shall be filed in accordance with standard reporting procedures for insurers, which procedures have received approval by the office, and shall contain data for the most recent policy period available. A statistical or rating organization may be used by insurers and self-insurance funds to report the data required by this section. The statistical or rating organization shall report each data element in the aggregate only for insurers and self-insurance funds required to report under this section who elect to have the organization report on their behalf. Such insurers and self-insurance funds shall be named in the report.

(3) Individual self-insurers as defined in s. 440.02 shall report only Florida data as prescribed in subparagraphs (2)(a)1.-5. ~~paragraphs (2)(a)-(c)~~ to the office.

(a) The office shall publish the dates and forms necessary to enable individual self-insurers to comply with this section.

(b) A statistical or rating organization may be used by individual self-insurers for the purposes of reporting the data required by this section and calculating experience ratings.

(4) The office may use the information it receives under this section in its adoption of rates and experience ratings modifications.

Section 13. Section 634.171, Florida Statutes, is amended to read:

634.171 Salesperson to be licensed and appointed.—Salespersons for motor vehicle service agreement companies and insurers shall be licensed, appointed, renewed, continued, reinstated, or terminated as prescribed in chapter 626 for insurance representatives in general. However, they shall be exempt from all other provisions of chapter 626 including fingerprinting, photo identification, education, and examination provisions. License, appointment, and other fees shall be those prescribed in s. 624.501. A licensed and appointed salesperson shall be directly responsible and accountable for all acts of her or his employees and other representatives. Each service agreement company or insurer shall, on forms prescribed by the department, within 30 days after termination of the appointment, notify the department of such termination. An ~~No~~ employee or salesperson of a motor vehicle service agreement company or insurer may not directly or indirectly solicit or negotiate insurance contracts, or hold herself or himself out in any manner to be an insurance agent, unless so qualified, licensed, and appointed therefor under the Florida Insurance Code. A licensed personal lines or general lines agent is not required to be licensed as a salesperson to advertise, solicit, negotiate, or sell motor vehicle service agreements. A motor vehicle service agreement company is not required to be licensed as a salesperson to solicit, sell, issue, or otherwise transact the motor vehicle service agreements issued by the motor vehicle

service agreement company.

Section 14. Section 634.317, Florida Statutes, is amended to read:

634.317 License and appointment required.—A ~~No~~ person may not solicit, negotiate, or effectuate home warranty contracts for remuneration in this state unless such person is licensed and appointed as a sales representative. A licensed and appointed sales representative shall be directly responsible and accountable for all acts of the licensee's employees. A licensed personal lines or general lines agent is not required to be licensed as a sales representative to advertise, solicit, negotiate, or sell home warranties.

Section 15. Section 634.419, Florida Statutes, is amended to read:

634.419 License and appointment required.—A ~~No~~ person or entity may not ~~shall~~ solicit, negotiate, advertise, or effectuate service warranty contracts in this state unless such person or entity is licensed and appointed as a sales representative. Sales representatives shall be responsible for the actions of persons under their supervision. However, a service warranty association licensed as such under this part shall not be required to be licensed and appointed as a sales representative to solicit, negotiate, advertise, or effectuate its products. A licensed personal lines or general lines agent is not required to be licensed as a sales representative to

advertise, solicit, negotiate, or sell service warranties.

Section 16. The Division of Law Revision is directed to create chapter 647, Florida Statutes, consisting of ss. 647.01-647.08, Florida Statutes, to be entitled "Travel Insurance."

Section 17. Section 647.01, Florida Statutes, is created to read:

647.01 Purpose and scope.—

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

(2) This chapter applies to:

(a) Travel insurance that covers any resident of this state and that is sold, solicited, negotiated, or offered in this state.

(b) Policies and certificates that are delivered or issued for delivery in this state.

This chapter does not apply to cancellation fee waivers or travel assistance services, except as expressly provided in this chapter.

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

Section 18. Section 647.02, Florida Statutes, is created to read:

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

(1) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(2) "Blanket travel insurance" means a policy of travel insurance issued to an eligible group providing coverage to all members of the eligible group without a separate charge to individual members of the eligible group.

(3) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(4) "Eligible group," solely for the purposes of travel insurance, means two or more persons who are engaged in a common enterprise or who have an economic, educational, or social affinity or relationship, including, but not limited to, any of the following:

(a) An entity engaged in the business of providing travel or travel services, including, but not limited to:

1. A tour operator, lodging provider, vacation property

owner, hotel, resort, travel club, travel agency, property manager, and cultural exchange program.

2. An operator, owner, or lessor of a means of transportation of passengers, including, but not limited to, a common carrier, airline, cruise line, railroad, steamship company, and public bus carrier.

With regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel.

(b) A university, college, school, or other institution of learning, covering students, teachers, employees, or volunteers.

(c) An employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests.

(d) A sports team or camp, or a sponsor thereof, covering participants, members, campers, employees, officials, supervisors, or volunteers.

(e) A religious, charitable, recreational, educational, or civic organization, or a branch thereof, covering any group of members, participants, or volunteers.

(f) A financial institution or financial institution vendor, or a parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including account holders, credit card

holders, debtors, guarantors, or purchasers.

(g) An incorporated or unincorporated association, including a labor union, having a common interest and constitution and bylaws, which is organized and maintained in good faith for purposes other than obtaining insurance coverage for its members or participants.

(h) A trust or the trustees of a fund that covers its members, employees, or customers and is established, created, or maintained for the benefit of its members, employees, or customers, subject to:

1. The department's authorizing the use of a trust.

2. The premium tax provisions in s. 647.03 applicable to incorporated or unincorporated associations that have a common interest and constitution and bylaws and that are organized and maintained in good faith for purposes other than obtaining insurance coverage for their members, employees, or customers.

(i) An entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers.

(j) A volunteer fire department, ambulance, rescue, police, court, first-aid, civil defense, or other such volunteer group.

(k) A preschool, daycare institution for children or adults, or senior citizen club.

(l) An automobile or truck rental or leasing company

covering a group of individuals who may become renters, lessees, or passengers as defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the motor vehicle or truck rental or leasing company is the policyholder under a policy to which this section applies.

(m) Any other group for which the department has made the following determinations:

1. The group members are engaged in a common enterprise or have an economic, educational, or social affinity or relationship.

2. Issuance of the travel insurance policy is not contrary to the public interest.

(5) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(6) "Group travel insurance" means travel insurance issued to an eligible group.

(7) "Limited lines travel insurance producer" means:

(a) A licensed or third-party administrator;

(b) A licensed insurance producer, including a limited lines producer; or

(c) A travel administrator.

(8) "Travel administrator" means a person who directly or

indirectly underwrites policies for, collects charges, collateral, or premiums from, or adjusts or settles claims on, residents of this state, in connection with travel insurance, except that a person is not considered a travel administrator if the person is:

(a) A person working for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(b) An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license;

(c) A travel retailer, as defined s. 626.321(1)(c)2., offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with s. 626.321(1)(c);

(d) A person adjusting or settling claims in the normal course of the person's practice or employment as an attorney at law, without collecting charges or premiums in connection with insurance coverage; or

(e) A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of the affiliated insurer.

(9) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and the provision of which does not result in

transfer or shifting of risk which would constitute the business of insurance. The term includes, but is not limited to, security advisories, destination information, vaccination and immunization information services, travel reservation services, entertainment, activity and event planning, translation assistance, emergency messaging, international legal and medical referrals, medical case monitoring, coordination of transportation arrangements, emergency cash transfer assistance, medical prescription replacement assistance, passport and travel document replacement assistance, lost luggage assistance, concierge services, and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and not related to insurance.

(10) "Travel insurance" means insurance coverage for personal risks incidental to planned travel, including:

(a) Interruption or cancellation of trip or event;

(b) Loss of baggage or personal effects;

(c) Damages to accommodations or rental vehicles;

(d) Sickness, accident, disability, or death occurring during travel;

(e) Emergency evacuation;

(f) Repatriation of remains; or

(g) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as determined by the office.

The term does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than 6 months, including major medical plans for those working or residing overseas as expatriates, or any other product that requires a specific insurance producer license.

(11) "Travel protection plan" means a plan that provides one or more of the following: travel insurance, travel assistance services, and cancellation fee waivers.

Section 19. Section 647.03, Florida Statutes, is created to read:

647.03 Premium tax.—

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

(a) "Primary certificateholder" means an individual who purchases travel insurance under a group travel insurance policy.

(b) "Primary policyholder" means an individual who purchases individual travel insurance.

(2) A travel insurer shall pay the premium tax, as required under s. 624.509, on travel insurance premiums paid by any of the following:

(a) A primary policyholder who is a resident of this state.

(b) A primary certificateholder who is a resident of this state.

(c) A blanket travel insurance policyholder:

1. Who is a resident in this state;

2. Who has his or her principal place of business in this state; or

3. Whose affiliate or subsidiary who has purchased blanket travel insurance for eligible blanket group members has his or her principal place of business in this state.

The premium tax under this subsection is subject to any apportionment rules that apply to an insurer across multiple taxing jurisdictions or that authorize an insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(3) A travel insurer shall:

(a) Document the state of residence or principal place of business of the policyholder or certificateholder, or an affiliate or subsidiary thereof, as required under subsection (2).

(b) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

Section 20. Section 647.04, Florida Statutes, is created to read:

647.04 Travel protection plans.—A travel protection plan may be offered for one price for the combined features that the

travel protection plan offers in this state if the travel protection plan meets all of the following requirements:

(1) The travel protection plan clearly discloses to the consumer, at or before the time of purchase, that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity, at or before the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each.

(2) The fulfillment materials:

(a) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan.

(b) Include the travel insurance disclosures required in this chapter, the contact information for persons providing travel assistance services, and cancellation fee waivers, as applicable.

Section 21. Section 647.05, Florida Statutes, is created to read:

647.05 Sales practices.—

(1)(a) All documents provided to a consumer before the purchase of travel insurance, including, but not limited to, sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy, including, but not limited to, forms, endorsements, policies, rate filings,

and certificates of insurance.

(b) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions must be provided any time before the purchase. Information on the exclusions and the opportunity to learn more about these exclusions must be included in the coverage's fulfillment materials.

(c) The fulfillment materials and the information described in s. 626.321(1)(c)3.a. must be provided to a policyholder or certificateholder as soon as practicable after the purchase of a travel protection plan. Unless the insured has started a covered trip or filed a claim under the travel insurance coverage, the policyholder or certificateholder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

1. Fifteen days after the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

2. Ten days after the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

For the purposes of this paragraph, the term "delivery" means handing fulfillment materials to the policyholder or

certificateholder or sending fulfillment materials by postal mail or electronic means to the policyholder or certificateholder.

(d) An insurer shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(e) If travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it is not an unfair trade practice or other violation of law if the following requirements are met:

1. The web page provides an accurate summary or short description of the coverage.

2. The consumer has access to the full provisions of the policy through electronic means.

(2) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may not do so by using a negative or opt-out option that would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

(3) If a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice to require that the consumer choose between the following options as a condition of purchasing a trip or travel package:

(a) Purchasing the coverage required by the destination

jurisdiction through the travel retailer, as defined s. 626.321(1)(c)2., or limited lines travel insurance producer supplying the trip or travel package; or

(b) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements before departure.

(4)(a) A person offering travel insurance to residents of this state is subject to part IX of chapter 626, the Unfair Insurance Trade Practices Act, except as otherwise provided in this chapter. If a conflict arises between this chapter and the Unfair Insurance Trade Practices Act regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this chapter shall control.

(b) A person commits an unfair insurance trade practice under the Unfair Insurance Trade Practices Act if the person:

1. Offers or sells a travel insurance policy that could never result in payment of any claims for any insured under the policy; or

2. Markets blanket travel insurance coverage as free.

Section 22. Section 647.06, Florida Statutes, is created to read:

647.06 Travel administrators.—

(1) Notwithstanding any other provision of the Florida Insurance Code, a person may not act or represent himself or herself as a travel administrator in this state unless the

person:

(a) Is a licensed and appointed property and casualty insurance producer in this state for activities authorized under that producer license;

(b) Is a licensed insurance agency, appointed as a managing general agent in this state; or

(c) Holds a valid third-party administrator license in this state.

(2) A travel administrator and its employees are exempt from the licensing requirements of part VI of chapter 626 for the travel insurance it administers.

(3) An insurer is responsible for ensuring that a travel administrator administering travel insurance underwritten by the insurer:

(a) Acts in accordance with this chapter.

(b) Maintains all books and records that are relevant to the insurer and makes these books and records available to the department upon request.

Section 23. Section 647.07, Florida Statutes, is created to read:

647.07 Travel insurance policy.—

(1) Notwithstanding any other provision of the Florida Insurance Code, travel insurance shall be classified and filed for purposes of rates and forms under the inland marine line of insurance; however, travel insurance that provides coverage for

sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits such as baggage or trip cancellation, may be classified and filed for purposes of rates and forms under either the accident and health line of insurance or the inland marine line of insurance.

(2) Travel insurance may be in the form of an individual, group travel insurance, or blanket policy. Group travel insurance or blanket policies are classified as commercial inland marine insurance under s. 627.021(2)(d). Travel insurance policies not issued to a commercial entity and primarily used for personal, family, or household purposes are considered personal inland marine insurance and are not subject to s. 627.062. Sections of policies or endorsements for travel insurance that are considered personal inland marine consisting of travel assistance services or cancellation fee waivers are not subject to s. 627.410.

(3) Travel insurance programs may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels.

Section 24. Section 647.08, Florida Statutes, is created to read:

647.08 Rulemaking authority.—The department shall adopt rules to administer this chapter.

Section 25. The amendments made by this act to ss. 316.646 and 320.02, Florida Statutes, and the creation of ss. 324.252 and 324.255, Florida Statutes, by this act shall take effect upon a specific appropriation.

Section 26. This act shall take effect July 1, 2020.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Santiago offered the following:

Amendment (with title amendment)

Remove lines 162-360

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

Remove lines 6-28 and insert:

in certain circumstances;

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Santiago offered the following:

Amendment (with title amendment)

Remove lines 627-673

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

Remove lines 59-66 and insert:

nonpayment; amending ss. 634.171, 634.317,

Amendment No. 3

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Santiago offered the following:

Amendment (with title amendment)

Remove lines 1101-1104

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

Remove line 107 and insert:

Services to adopt rules;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1387 Sale of Surplus State-owned Lands
SPONSOR(S): Grant, J.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1714

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Government Operations & Technology Appropriations Subcommittee	12 Y, 0 N	Keith	Topp
2) State Affairs Committee	20 Y, 0 N	Etheridge	Williamson
3) Appropriations Committee		Keith AK	Pridgeon

SUMMARY ANALYSIS

The Board of Trustees (board) of the Internal Improvement Trust Fund is tasked with determining which state-owned lands, the title to which is vested in the board, may be surplused. Before a building or parcel of land is offered for lease or sale to a local or federal unit of government or a private party, it must first be offered for lease to state agencies, state universities, and Florida College System institutions, with priority consideration given to state universities and Florida College System institutions. Funds received from the sale of surplus nonconservation lands or lands that were acquired by gift, donation, or for no consideration must be deposited into the Internal Improvement Trust Fund.

The Architects Incidental Trust Fund was created for the purpose of providing sufficient funds for the operation of the facilities development activities of the Department of Management Services (department). The department may levy and assess an amount necessary to cover the cost of administration by the department of fixed capital outlay projects on which it serves as owner representative on behalf of the state. The fund is used to preserve the integrity of funds collected from fixed capital outlay projects and to document the expenditure and utilization of such funds. The primary sources of revenue for the fund comes from construction fees from other state agencies, assessments on state fixed capital outlay projects, direct supplemental contracts, and interest earnings.

The bill removes the requirement that a building or parcel of land must be offered to state universities or Florida College System institutions prior to being offered for lease or sale. The bill also provides requirements for determining the value of surplus lands to be based on the highest and best use of the property considering all applicable developmental rights to ensure the highest value to the state.

The bill clarifies that only funds received from the sale of surplus state-owned office buildings and the nonconservation lands associated with such buildings must be deposited into the Architects Incidental Trust Fund and that the funds may only be used for specific operational and facilities development activities of the department.

The bill may have a neutral, yet indeterminate fiscal impact to state government revenues and no fiscal impact to local government. *See* Fiscal Comments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Architects Incidental Trust Fund

The Architects Incidental Trust Fund was created for the purpose of providing sufficient funds for the operation of the facilities development activities of the Department of Management Services (department).[1] The department may levy and assess an amount necessary to cover the cost of administration by the department of fixed capital outlay projects on which it serves as owner representative on behalf of the state. The assessment rate is provided in the General Appropriations Act based on estimated operating cost projections for the services to be rendered. The total assessment of funds collected from various fixed capital outlay projects is transferred into the Architects Incidental Trust Fund at the beginning of each fiscal year.[2]

The trust fund is used to preserve the integrity of funds collected from fixed capital outlay projects and to document the expenditures and utilization of such funds. The primary sources of revenue for the fund comes from construction fees from other state agencies, assessments on state fixed capital outlay projects, direct supplemental contracts, and interest earnings.

Surplus of State-Owned Lands

The Board of Trustees (board) of the Internal Improvement Trust Fund[3] is tasked with determining which state-owned lands, the title to which is vested in the board, may be surplused.[4] Before a building or parcel of land is offered for lease or sale to a local or federal unit of government or a private party, it must first be offered for lease to state agencies, state universities, and Florida College System institutions, with priority consideration given to state universities and Florida College System institutions.[5]

Within 60 days after an offer for lease of a surplus building or parcel, a state university or Florida College System institution requesting the lease must submit a plan for review and approval by the Board regarding the intended use, including any future use, of the building or parcel of land before approval of any lease.[6] State agencies that request the lease of such facilities or parcels must also submit a plan within 60 days for review and approval by the Board.[7] The state agency plan must include the intended use, including at a minimum, the proposed use of the facility or parcel, the estimated cost of renovation, a capital improvement plan for the building, evidence that the building or parcel meets an existing need that cannot otherwise be met, and other criteria required by board rules.[8]

In current practice, the lease can be executed for up to 50 years. Pursuant to Rule 18-2.020(8), F.A.C., an annual administrative fee of $300 to occupy state-owned nonconservation land is assessed in July of each year.[9] There are no other fees, such as lease fees, assessed to a state university or Florida College System institution if a state-owned building and associated non-conservation land is determined to be suited for sale, and a state agency, state university, or Florida College System institution claims the first right of lease.[10]

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[1] S. 215.196(1), F.S.
[2] S. 215.196(2), F.S.
[3] S. 253.001, F.S.
[4] S. 253.0341(1), F.S.
[5] S. 253.0341(7), F.S.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] R. 18-2.020(8), F.A.C.
[10] Department of Management Services, Agency Analysis of 2020 House Bill 1387, p. 2 (Jan. 29, 2020).

Funds received from the sale of surplus nonconservation lands or lands that were acquired by gift, donation, or for no consideration are deposited into the Internal Improvement Trust Fund.[11]

Effect of the Bill

The bill amends s. 215.196, F.S., requiring that funds received from the sale of surplus state-owned office buildings, as defined in s. 255.248, F.S., and the nonconservation lands associated with such buildings, must be deposited into the Architects Incidental Trust Fund. The bill also requires that the trust fund deposits are for providing sufficient funds for the operation of the facilities development activities of the department and to acquire, lease, plan, entitle, design, permit, construct, or maintain state-owned office buildings as defined in s. 255.248(9), F.S., and nonconservation lands associated with such buildings.

The bill amends s. 253.0341, F.S., removing a requirement that a state-owned building or parcel of land be offered to state universities or Florida College System institutions prior to being offered for lease or sale. The bill also provides requirements for determining the value of surplus lands to be based on the highest and best use of the property considering all applicable developmental rights to ensure the highest value to the state as provided in s. 253.03(7)(a), F.S. The bill defines the term "highest and best use" as the reasonable, probable, and legal use of vacant land or an improved property that is physically possible, appropriately supported, financially feasible, and results in the highest value.

The bill clarifies that only funds received from the sale of surplus state-owned office buildings, and the nonconservation lands associated with such buildings must be deposited into the Architects Incidental Trust Fund. The funds that would be received from the sale of surplus nonconservation lands or lands that were acquired by gift, donation, or for no consideration will continue to be deposited into the Internal Improvement Trust Fund as required by current law.[12]

B. SECTION DIRECTORY:

Section 1. Amends s. 215.196, F.S., relating to the deposit of funds into the Architects Incidental Trust Fund within the department.

Section 2. Amends s. 253.0341, F.S., relating to sale of surplus state-owned buildings and lands.

Section 3. Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[11] S. 253.0341(14), F.S.
[12] *Id.*

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill may have a neutral, yet indeterminate fiscal impact to state government revenues. There could be an increase in state revenues if a state-owned office building and the associated nonconservation land is sold, and the funds are deposited into the Architects Incidental Trust Fund within the Department of Management Services. Conversely, there could be a negative impact to the Internal Improvement Trust Fund related to funds that would have otherwise been received prior to provisions in the bill redirecting them to the Architects Incidental Trust Fund. Any proceeds from the sale of state-owned buildings and nonconservation lands would remain in the Architects Incidental Trust Fund until an appropriation is provided by the Legislature.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not grant rulemaking authority, nor does it require a grant of rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to the sale of surplus state-owned lands; amending s. 215.196, F.S.; requiring funds from the sale of surplus state-owned buildings and associated nonconservation lands to be deposited in the Architects Incidental Trust Fund and used for specified purposes; amending s. 253.0341, F.S.; removing the requirement that surplus state-owned buildings and lands be offered for lease or sale to state universities and Florida College System institutions before being offered to state agencies; providing a requirement for determining the value of surplus lands; defining the term "highest and best use"; requiring funds from the sale of surplus state-owned buildings and associated nonconservation lands be deposited into the Architects Incidental Trust Fund; providing an effective date.

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

Section 1. Subsection (3) is added to section 215.196, Florida Statutes, to read:

215.196 Architects Incidental Trust Fund; creation; assessment.—

(3) Funds received from the sale of surplus state-owned

office buildings as defined in s. 255.248 and the nonconservation lands associated with such buildings pursuant to s. 253.0341(14)(b) shall be deposited in the Architects Incidental Trust Fund for the purpose of providing sufficient funds for the operation of the facilities development activities of the Department of Management Services and to acquire, lease, plan, entitle, design, permit, construct, or maintain state-owned office buildings as defined in s. 255.248(9) and nonconservation lands associated with such buildings.

Section 2. Subsections (7), (8), and (14) of section 253.0341, Florida Statutes, are amended to read:

253.0341 Surplus of state-owned lands.—

(7) Before a building or parcel of land is offered for lease or sale to a local or federal unit of government or a private party, it shall first be offered for lease to state agencies~~, state universities, and Florida College System institutions, with priority consideration given to state universities and Florida College System institutions. Within 60 days after the offer for lease of a surplus building or parcel, a state university or Florida College System institution that requests the lease must submit a plan for review and approval by the Board of Trustees of the Internal Improvement Trust Fund regarding the intended use, including future use, of the building or parcel of land before approval of a lease~~. Within 60 days after the offer for lease of a surplus building or parcel,

a state agency that requests the lease of such facility or parcel must submit a plan for review and approval by the board of trustees regarding the intended use. The state agency plan must, at a minimum, include the proposed use of the facility or parcel, the estimated cost of renovation, a capital improvement plan for the building, evidence that the building or parcel meets an existing need that cannot otherwise be met, and other criteria developed by rule by the board of trustees. The board or its designee shall compare the estimated value of the building or parcel to any submitted business plan to determine if the lease or sale is in the best interest of the state. The board of trustees shall adopt rules pursuant to chapter 120 for the implementation of this section.

(8) The sale price of lands determined to be surplus pursuant to this section and s. 253.82 shall be determined by the Division of State Lands, which shall consider an appraisal of the property or, if the estimated value of the land is $500,000 or less, a comparable sales analysis or a broker's opinion of value. The division may require a second appraisal. The individual or entity that requests to purchase the surplus parcel shall pay all costs associated with determining the property's value, if any.

(a) A written valuation of land determined to be surplus pursuant to this section and s. 253.82, and related documents used to form the valuation or which pertain to the valuation,

are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

1. The exemption expires 2 weeks before the contract or agreement regarding the purchase, exchange, or disposal of the surplus land is first considered for approval by the board of trustees.

2. Before expiration of the exemption, the Division of State Lands may disclose confidential and exempt appraisals, valuations, or valuation information regarding surplus land:

a. During negotiations for the sale or exchange of the land;

b. During the marketing effort or bidding process associated with the sale, disposal, or exchange of the land to facilitate closure of such effort or process;

c. When the passage of time has made the conclusions of value invalid; or

d. When negotiations or marketing efforts concerning the land are concluded.

(b) A unit of government that acquires title to lands pursuant to this section for less than appraised value may not sell or transfer title to all or any portion of the lands to any private owner for 10 years. A unit of government seeking to transfer or sell lands pursuant to this paragraph must first allow the board of trustees to reacquire such lands for the price at which the board of trustees sold such lands.

(c) For the purposes of determining the value of surplus lands pursuant to this subsection, the value shall be based on the highest and best use of the property considering all applicable developmental rights to ensure the highest value to the state as provided in s. 253.03(7)(a). As used in this paragraph, the term "highest and best use" means the reasonable, probable, and legal use of vacant land or an improved property that is physically possible, appropriately supported, financially feasible, and that results in the highest value.

(14)(a) Funds received from the sale of surplus nonconservation lands or lands that were acquired by gift, by donation, or for no consideration shall be deposited into the Internal Improvement Trust Fund.

(b) Notwithstanding paragraph (a), funds received from the sale of surplus state-owned office buildings as defined in s. 255.248 and the nonconservation lands associated with such buildings pursuant to this section shall be deposited into the Architects Incidental Trust Fund.

Section 3. This act shall take effect July 1, 2020.

STORAGE NAME: h6507.CJS
DATE: 1/18/2020

January 18, 2020

SPECIAL MASTER'S FINAL REPORT

The Honorable Jose R. Oliva
Speaker, The Florida House of Representatives
Suite 420, The Capitol
Tallahassee, Florida 32399-1300

Re: HB 6507 - Representative Daniels and others
Relief/Clifford Williams/State of Florida

THIS IS AN EQUITABLE CLAIM FOR $2,150,000 TO COMPENSATE CLIFFORD WILLIAMS FOR NEARLY 43 YEARS OF WRONGFUL INCARCERATION.

FINDINGS OF FACT:

In 1976, 34-year-old Clifford Williams ("Claimant") and his nephew, 18-year-old Hubert Nathan Myers, were convicted of the murder of Jeanette Williams,[1] the attempted murder of Nina Marshall, and burglary. In turn, they were sentenced to prison and incarcerated for nearly 43 years.

On May 2, 1976, at about 1:30 a.m., Jeanette Williams and her girlfriend, Nina Marshall, were shot while asleep in bed. Ms. Williams died instantly, but Ms. Marshall survived. She stumbled out of her apartment, flagged down a passing car, and went to the hospital, where she identified her assailants as Claimant and Mr. Myers.

Claimant and Mr. Myers maintained their innocence, stating that they were at the birthday party of a Rachael Jones at the time of the shooting, just down the street. After the police arrived, Claimant and Mr. Myers were among a group of onlookers who

[1] Jeanette Williams was not related to Claimant.

came down the street near the crime scene. Many of the attendants at the birthday party confirmed that Claimant and Mr. Myers were at the party when gunfire was heard. Despite their alibis and based solely on Ms. Marshall's identifying statement, Claimant and Mr. Myers were arrested less than two hours after the shooting.

PROCEDURAL HISTORY:

Conviction and Sentencing

Two months after being arrested, Claimant and Mr. Myers were jointly tried, resulting in a mistrial from an error. During the retrial, the State offered Mr. Myers five years in prison in exchange for testimony against his uncle, the Claimant. Then-18-year-old Myers, who had never been convicted of a felony and who was facing the death penalty, rejected the State's offer. Both men were subsequently convicted, following a two-day trial.

The jury recommended life imprisonment for both defendants, but the trial judge overrode the jury's recommendation and sentenced Claimant to death. On appeal, the Florida Supreme Court reduced Claimant's death sentence to a life sentence, finding no aggravating factors.[2] As a result, both Claimant and Mr. Myers were ultimately given life sentences.

State Attorney's Conviction Integrity Unit

In 2007, prosecutors' offices around the country began developing conviction integrity units to review claims of wrongful conviction. In January 2018, Melissa Nelson, the State Attorney for Florida's Fourth Judicial Circuit, created Florida's first conviction integrity review unit.

The conviction integrity review division (CIR) within the State Attorney's Office investigates claims of actual innocence, providing analysis and assistance to prevent errors leading to injustice. The CIR investigates claims arising from felony convictions that are capable of being substantiated by credible, factual information or evidence not considered by the original factfinder.

A person claiming wrongful incarceration may file with the CIR a petition, which is reviewed by the division director and an investigator. If the petition meets applicable criteria, the CIR opens an investigation, which may involve:

- A review of agency files or other relevant documents;
- A review of legal briefs and transcripts;
- Witness interviews;
- Obtaining sworn statements; and
- Submission of evidence for testing or retesting.

[2] *Williams v. State*, 386 So. 2d 538 (Fla. 1980).

After the CIR concludes its independent review and investigation, it submits its report and recommendation to an Independent Audit Board (IAB) comprised of five members of the community. The IAB reviews the CIR's findings to verify that the CIR's recommendation is supported by substantial and credible information. The State Attorney makes the final decision on the matter.[3]

State Attorney's CIR Investigation into Claimant's Case

On January 17, 2017, Claimant's nephew and co-defendant, Mr. Myers, wrote to the State Attorney's Office, claiming innocence for the crimes involving Ms. Williams and Ms. Marshall. The State Attorney's Office accepted review of the case and began a comprehensive investigation.

The State's investigation led to several discoveries weighing against Claimant's guilt. Specifically, the State's investigation confirmed that:

- Another man—Nathaniel Lawson—admitted to several people that he shot the victims through a window because Ms. Williams had stolen heroin from him; and regretted that Claimant and Mr. Myers were serving time for his own crime.[4]
- Nathaniel Lawson was present at the scene at the time of the shooting.[5]
- Multiple witnesses recalled being with both Claimant and Mr. Myers at the nearby party when shots were heard, indicating that Claimant had a reasonable alibi on the night of the crimes.

The CIR ultimately found significant exculpatory evidence indicating that Claimant and Mr. Myers did not commit the crimes. The State Attorney's CIR report summarized the evidence of Claimant's and Mr. Myers's innocence as follows:

> Every investigative step the CIR took corroborated Defendant Myers' claim of innocence, and placed into doubt Ms. Marshall's identification. While no single item of evidence, in and of itself, exonerates Defendant Myers or Defendant Williams, **the culmination of all the evidence, most of which the jury never heard or saw, leaves no abiding confidence in the convictions or the guilt of the defendants.** It is the opinion of the CIR that these men would not be convicted by a jury today if represented by competent counsel who presented all of

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[3] *See* Conviction Integrity Investigation, *State v. Myers* and *State v. Williams*, at 1 (Mar. 27, 2019), https://secureservercdn.net/198.71.233.254/9c2.a8b.myftpupload.com/wp-content/uploads/2019/03/CIR_Investigative_Report_FINAL_3.28.19_R.pdf (last visited Jan. 18, 2020).

[4] Nathaniel Lawson died in 1994; however, the people to whom he made his incriminating admissions are still alive. Conviction Integrity Investigation at 4.

[5] During the CIR investigation, Claimant offered to take a polygraph test but was unable to complete the test due to diminished cognitive ability. Conviction Integrity Investigation at 4 n.8.

the exculpatory evidence that exists in this case for the jury's consideration.[6]

On March 28, 2019, with the consent of the State,[7] the circuit court vacated Claimant's convictions and sentences relating to the May 2, 1976, shootings of Jeanette Williams and Nina Marshall.[8]

Wrongful Incarceration Proceedings

Nathan Myers, Claimant's nephew and codefendant, filed a wrongful incarceration petition under chapter 961, F.S. On September 10, 2019, the circuit court granted the petition, finding that Mr. Myers had "met the burden of establishing by clear and convincing evidence" that he did not commit the crimes serving as the basis for his conviction and incarceration.[9]

While Mr. Myers was able to obtain relief under chapter 961, Claimant was ineligible do so because of that chapter's "clean hands provision," which eliminates from consideration any petitioner who, before or during his or her wrongful incarceration, was convicted of two felonies.[10]

CLAIMANT'S POSITION: Claimant asserts that he is actually innocent of the charges and seeks monetary compensation for his time in prison, as well as a tuition waiver for 120 hours of career center or college instruction.

RESPONDENT'S POSITION: Officially, Respondent neither supports nor opposes the claim bill. However, Claimant's exoneration stems from the Respondent's establishment of the Wrongful Conviction Unit in the State Attorney's Office, which stated, in its official report, that "after review and reinvestigation of the case, evidence, and trial, the State of Florida no longer has confidence in the integrity of the convictions or guilt of the accused."[11]

CONCLUSIONS OF LAW: Wrongful Incarceration under Chapter 961

Chapter 961, Florida Statutes, governs the general process for compensating victims of wrongful incarceration. Chapter 961 requires a person claiming to be a victim of wrongful incarceration to prove that he or she is actually innocent of the crime and meet other criteria, such as not having been previously convicted of multiple felonies.[12]

Here, Claimant has been unable to obtain relief under chapter

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[6] Conviction Integrity Investigation at 4 (emphasis added).
[7] *See* Office of the State Attorney for the Fourth Judicial Circuit, *Conviction Integrity Review of 1976 Case Leads to Release of Williams, Myers*, https://www.sao4th.com/conviction-integrity-williams-myers/ (last visited Jan. 18, 2020).
[8] Duval Co. Case No. 76-CF-000912 (Order Vacating Defendant's Judgment and Sentences) (Mar. 28, 2019).
[9] Duval Co. Case No. 76-CF-000912 (Order Granting Petition for Wrongful Incarceration) (Sept. 10, 2019).
[10] S. 961.04(1) and (2), F.S. (prohibiting relief for a person committing a violent felony or more than one non-violent felony).
[11] Conviction Integrity Investigation at 1 (Mar. 27, 2019).
[12] *See* ss. 961.03, 961.04, F.S.

961 because he was convicted of two felonies prior to his convictions for the shootings of Ms. Williams and Ms. Marshall. The first was a conviction for attempted arson in 1960, for which he served two years in county jail; and the second was a conviction for robbery in 1966. Even though Claimant is ineligible under the chapter 961 process, the Legislature is not bound by that process and may pass this claim bill regardless of whether Claimant could otherwise obtain relief.

Evidentiary Standard for Victims of Wrongful Incarceration

Generally, a claimant seeking tort damages under a claim bill must prove entitlement to relief by a preponderance of the evidence—that is, more likely than not. When a claimant seeks a claim bill for wrongful incarceration, he or she must demonstrate actual innocence, but the appropriate burden of proof is not well-established.

William Dillon was the first and only person to receive a claim bill for wrongful incarceration since the enactment of chapter 961, F.S. Mr. Dillon argued that the Legislature should apply a "preponderance of the evidence" standard. The Senate Special Master agreed, but the House Special Master applied a "clear and convincing" standard. This standard is an intermediate burden of proof requiring that the evidence is of "such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established."[13] Applying this more exacting standard, the House Special Master found that Mr. Dillon had proven actual innocence.

Here, the Legislature is not bound by a previous Legislature's application of the clear and convincing standard. Still, the Legislature's previous application of that standard, coupled with the Legislature's requirement of that same standard for every other person claiming to be a victim of wrongful incarceration, demonstrates that this standard is appropriate for wrongful incarceration cases.[14]

Because the Legislature has demonstrated an intent to hold persons claiming to be victims of wrongful incarceration to this higher evidentiary standard, I find that the clear and convincing standard should apply, in accordance with House precedent and legislative intent.

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[13] *See S. Fla. Water Mgmt. Dist. v. RLI Live Oak, LLC*, 139 So. 3d 869, 872 (Fla. 2014).

[14] *See* s. 961.03(3), F.S. (requiring that a victim of wrongful incarceration is entitled to relief if he or she can present "clear and convincing evidence that [he or she] committed neither the act nor the offense that served as the basis for the conviction and incarceration," among other requirements). Moreover, while not dispositive as to legislative intent, it would seem odd to require a person with "clean hands" seeking relief under chapter 961, F.S., to prove his innocence by a clear and convincing standard, while requiring a person not eligible under chapter 961, F.S., to prove his innocence by the lesser preponderance of the evidence standard.

Application of Burden of Proof to Claimant's Case

Throughout this process, Claimant has successfully demonstrated his actual innocence by clear and convincing evidence. Specifically, I find the following to be persuasive:

- There are multiple credible alibi witnesses who were not called to testify at trial;
- There is a sworn affidavit stating that Nathaniel Lawson confessed to the crimes before he died;
- Nathaniel Lawson was placed at the scene on the night of the crime;
- Ms. Marshall's testimony has changed throughout the proceedings, demonstrating that she is not a credible witness;
- Ms. Marshall's testimony is rebutted by the scientific and physical evidence in the case;
- There is evidence demonstrating that the gunshots were likely fired from the outside of the apartment, not from the inside as Ms. Marshall testified;
- There was clothing draped over the inside bedroom door, preventing the door from closing, which undercuts Ms. Marshall's testimony that her assailant closed the door after leaving;
- Claimant and his codefendant Mr. Myers have consistently maintained their innocence; and
- Mr. Myers took and passed a polygraph test.

Moreover, I give great weight to the fact that Claimant's innocence came to light through the State's own investigation. The Conviction Integrity Review Division within the State Attorney's Office stated in its official report that "[t]here is no credible evidence of guilt, and likewise, there is credible evidence of innocence"; and recommended a determination that the office has lost faith in the convictions of Claimant and Mr. Myers.[15] In turn, the State Attorney did not oppose Claimant's motion for postconviction relief and has not opposed this claim bill.

I find that Claimant has successfully demonstrated, by clear and convincing evidence, that he is actually innocent of the crimes for which he was convicted in 1976.

Amount of Claim Bill

Claimant seeks a total monetary award of $2,150,000, which is $50,000 for each of the 43 years that he was wrongfully incarcerated. While $50,000 is the appropriate amount for each year of wrongful incarceration under chapter 961, F.S., that chapter also limits the total amount that can be recovered to $2,000,000.[16] While the Legislature is not limited by chapter 961's cap in this claim bill proceeding, the Legislature may decide that Claimant should not recover more than other similarly-situated petitioners eligible under the normal chapter

961 process.

On the other hand, given that Claimant has lost nearly forty-three years of his most valuable years serving time for a crime he did not commit, the Legislature may decide that the full amount sought is equitable under these particular circumstances.

Exhaustion of Remedies

House Rule 5.6(c) requires a claim bill to be held in abeyance until a claimant has exhausted "all available administrative and judicial remedies. . . ." Here, Claimant has exhausted his remedies under the normal chapter 961 process; however, he currently has a lawsuit pending wherein he claims that the "clean hands" and monetary cap portions of chapter 961 are unconstitutional as applied to him. It is true that if the court agrees and holds those portions of chapter 961 unconstitutional, he will presumably be able to pursue compensation under that revised version of chapter 961. As it now stands, however, Claimant is ineligible for relief under chapter 961. Accordingly, I recommend the Legislature find that he has exhausted his remedies for purposes of Rule 5.6(c).[17]

ATTORNEY'S/ LOBBYING FEES: Claimant's attorneys are providing representation on a pro bono basis. There are no attorney fees, lobbying fees, or costs associated with this claim bill.

RESPONDENT'S ABILITY TO PAY: Because any award would presumably come from the General Revenue Fund, it would not affect Respondent's operations.

LEGISLATIVE HISTORY: This is the first session this bill has been presented to the Legislature.

RECOMMENDATION: Because Claimant has demonstrated by clear and convincing evidence that he is actually innocent of the crimes for which he was convicted in 1976, I recommend that House Bill 6507 be reported **FAVORABLY**.

Respectfully submitted,

W. Jordan Jones

JORDAN JONES

House Special Master

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[15] Conviction Integrity Investigation at 44.

[16] S. 961.06(1)(a), F.S. ("Monetary compensation for wrongful incarceration [shall] be calculated at a rate of $50,000 for each year of wrongful incarceration"); s. 961.06(1)(e), F.S. ("The total compensation awarded under [paragraph] (a) . . . may not exceed $2 million").

[17] Notably, Senate Rule 4.81(6), while including a similar exhaustion of remedies requirement, states that such requirement "does not apply to a bill which relates to a claim of wrongful incarceration."

cc: Representative Daniels, House Sponsor
Senator Gibson, Senate Sponsor
Christie Letarte, Senate Special Master

A bill to be entitled

An act for the relief of Clifford Williams; providing an appropriation to compensate him for being wrongfully incarcerated for 43 years; directing the Chief Financial Officer to draw a warrant for the purchase of an annuity; requiring the Department of Financial Services to pay specified funds; providing for the waiver of certain tuition and fees for Mr. Williams; specifying conditions for payment; providing that the act does not waive certain defenses or increase the state's limits of liability; prohibiting any further award to include certain fees and costs; providing that certain benefits are vacated upon specified findings; providing an effective date.

WHEREAS, Clifford Williams was arrested on May 2, 1976, and convicted of first-degree murder and first-degree attempted murder on September 2, 1976, and

WHEREAS, Clifford Williams spent 4 years on death row before the Florida Supreme Court reversed his death sentence in 1980, and

WHEREAS, Clifford Williams has maintained his innocence, and

WHEREAS, on February 25, 2019, the Conviction Integrity Review Division (CIR) for the Office of the State Attorney for

the Fourth Judicial Circuit issued a report and recommendation, based on a comprehensive investigation spanning nearly a year, in Clifford Williams' case, and

WHEREAS, on March 28, 2019, the Circuit Court for the Fourth Judicial Circuit granted, with the concurrence of the state, a motion for postconviction relief, vacated the judgment and sentence of Clifford Williams, and ordered a new trial, and

WHEREAS, on March 28, 2019, the state orally pronounced a nolle prosequi with regard to the retrial of Clifford Williams, and

WHEREAS, the report found that there was no credible evidence of Clifford Williams' guilt, and likewise, that there was substantial credible evidence of Clifford Williams' innocence, and

WHEREAS, the Legislature acknowledges that the state's system of justice yielded an imperfect result that had tragic consequences in this case, and

WHEREAS, the Legislature acknowledges that, as a result of his physical confinement, Clifford Williams suffered significant damages that are unique to Clifford Williams, and such damages are due to the fact that he was physically restrained and prevented from exercising the freedom to which all innocent citizens are entitled, and

WHEREAS, before his conviction for the above-mentioned crimes, Clifford Williams had two prior convictions for

unrelated felonies, and

WHEREAS, because of his prior violent felony convictions, Clifford Williams is ineligible for compensation under chapter 961, Florida Statutes, and

WHEREAS, the Legislature is providing compensation to Clifford Williams to acknowledge the fact that he suffered significant damages that are unique to Clifford Williams for being wrongfully incarcerated, and

WHEREAS, the CIR's comprehensive investigation of the matter found verifiable and substantial evidence of Clifford Williams' actual innocence of first-degree murder and first-degree attempted murder, and

WHEREAS, the Legislature apologizes to Clifford Williams on behalf of the state, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of $2,150,000 is appropriated from the General Revenue Fund to the Department of Financial Services under the conditions provided in this act.

Section 3. The Chief Financial Officer is directed to draw a warrant in the sum specified in section 2 for the purposes provided in this act.

Section 4. The Department of Financial Services shall pay the funds appropriated under this act to an insurance company or other financial institution admitted and authorized to issue annuity contracts in this state and selected by Clifford Williams to purchase an annuity. The Chief Financial Officer shall execute all necessary agreements to implement this act and to maximize the benefit to Clifford Williams.

Section 5. Tuition and fees for Clifford Williams shall be waived for up to a total of 120 hours of instruction at any career center established pursuant to s. 1001.44, Florida Statutes, Florida College System institution established under part III of chapter 1004, Florida Statutes, or state university. For any educational benefit made, Clifford Williams must meet and maintain the regular admission and registration requirements of such career center, institution, or state university and make satisfactory academic progress as defined by the educational institution in which he is enrolled.

Section 6. The Chief Financial Officer shall purchase the annuity as required by this act upon delivery by Clifford Williams to the Chief Financial Officer, the Department of Financial Services, the President of the Senate, and the Speaker of the House of Representatives of a release executed by Clifford Williams for himself and on behalf of his heirs, successors, and assigns which fully and forever releases and discharges the state and its agencies and subdivisions, as

defined by s. 768.28(2), Florida Statutes, from any and all present or future claims or declaratory relief that Clifford Williams or any of his heirs, successors, or assigns may have against the state and its agencies and subdivisions, as defined by s. 768.28(2), Florida Statutes, arising out of the factual situation in connection with the arrest, conviction, and incarceration for which compensation is awarded. Without limitation on the foregoing, the release must specifically release and discharge Sheriff Mike Williams of the Jacksonville Sheriff's Office in his official capacity, and any current or former sheriffs, deputies, agents, or employees of the Jacksonville Sheriff's Office in their individual capacities, from all claims, causes of action, demands, rights, and claims for attorney fees or costs, of whatever kind or nature, whether in law or equity, including, but not limited to, any claims pursuant to 42 U.S.C. s. 1983, that Clifford Williams had, has, or might hereinafter have or claim to have, whether known or not, against the Jacksonville Sheriff's Office, and Sheriff Mike Williams' assigns, successors in interest, predecessors in interest, heirs, employees, agents, servants, officers, directors, deputies, insurers, reinsurers, and excess insurers, in their official and individual capacities, and that arise out of, are associated with, or are a cause of the arrest, conviction, and incarceration for which compensation is awarded, including any known or unknown loss, injury, or damage related

to or caused by the same and which may arise in the future. However, this act does not prohibit declaratory action by a judicial or executive branch agency, as otherwise provided by law, for Clifford Williams to obtain judicial expungement of his criminal history record as related to the arrest and convictions for first-degree murder and first-degree attempted murder.

Section 7. The Legislature does not waive any defense of sovereign immunity or increase the limits of liability on behalf of the state or any person or entity that is subject to s. 768.28, Florida Statutes, or any other law.

Section 8. This award is intended to provide the sole compensation for any and all present and future claims arising out of the factual situation described in this act which resulted in Clifford Williams' arrest, conviction, and incarceration. There may not be any further award to include attorney fees, lobbying fees, costs, or other similar expenses to Clifford Williams by the state or any agency, instrumentality, or political subdivision thereof, or any other entity, including any county constitutional officer, officer, or employee, in state or federal court.

Section 9. If any future factual finding determines that Clifford Williams, by DNA evidence or otherwise, participated in any manner related to the death of Jeanette Williams or the attempted murder of Nina Marshall, the unused benefits to which Clifford Williams is entitled under this act are vacated.

Section 10. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7059 PCB JDC 20-05 Jurisdiction of Appellate Courts
SPONSOR(S): Judiciary Committee, Fernandez-Barquin
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1510

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Judiciary Committee	16 Y, 1 N	Jones	Luczynski
1) Appropriations Committee		Smith	Pridgeon

SUMMARY ANALYSIS

The State Constitution establishes a four-level court system consisting of a supreme court, five district courts of appeal (DCAs), 20 circuit courts, and 67 county courts. The circuit courts and county courts primarily serve as trial courts, but the circuit courts also hear appeals from county courts involving many different types of cases and appeals from administrative bodies. A decision of a circuit court sitting as a trial court is generally appealable to the DCA.

Under current law, circuit courts have appellate jurisdiction over cases appealed from county court, except:

- Appeals where the amount in controversy is greater than $15,000.
- Appeals of orders declaring invalid a statutory or constitutional provision.
- Appeals of orders certified to be matters of great public importance, which are accepted by a DCA for review.

Circuit courts also have jurisdiction over appeals from final administrative orders of local government code enforcement boards.

Last session, the Legislature passed CS/CS/HB 337 (2019), which limited circuit court appellate jurisdiction to civil cases appealed from county court with an amount in controversy of $15,000 or less. This provision will be automatically repealed on January 1, 2023.

HB 7059 eliminates appellate jurisdiction of circuit courts for cases originating in county court, which will cause a DCA to have appellate jurisdiction of final orders entered by county courts in civil and criminal cases. The bill allows circuit courts to continue to exercise jurisdiction over:

- Appeals from final administrative orders of local government code enforcement boards.
- Reviews and appeals as otherwise expressly provided by law.

The bill would have an indeterminate fiscal impact on state government and local governments.

The bill provides an effective date of January 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The State Constitution establishes a four-level court system consisting of a supreme court, five district courts of appeal (DCAs), 20 circuit courts, and 67 county courts.[1] The circuit courts and county courts primarily serve as trial courts, but the circuit courts also hear appeals from county courts involving many different types of cases and appeals from administrative bodies. After a case is decided by a circuit court sitting as a trial court, the losing party generally has the right to appeal to the appropriate DCA.[2]

The Constitution also permits the Legislature to substantially define the jurisdictions of the circuit courts and county courts by statute.[3] As defined by statute, the circuit court has exclusive jurisdiction over several case types, including felony cases and probate matters, but the primary distinction between the jurisdictions of the courts is a monetary threshold.[4]

Recent Legislative Changes to Trial Court Jurisdiction

During the 2019 Legislative Session, the Legislature increased the monetary threshold to expand the jurisdiction of the county courts. Since 1995, this threshold was $15,000.[5] Claims exceeding $15,000 were filed in circuit court, and county courts had jurisdiction to hear claims valued up to that amount. With the 2019 legislation, effective January 1, 2020, the threshold became $30,000. The threshold increases again automatically on January 1, 2023, to $50,000.

Although the 2019 legislation increased the value of claims that could be litigated in county court, the legislation did not also increase the jurisdiction of circuit courts to hear appeals from county courts. Appeals of county court orders or judgments where the amount in controversy is greater than $15,000 will continue to be heard by a DCA until January 1, 2023.[6] Appeals of county court orders or judgments involving amounts of $15,000 or less will continue to be heard in circuit court.

Supreme Court's Recommended Changes to Appellate Court Jurisdiction

About the same time the 2019 legislation was filed increasing the monetary jurisdictional threshold, the Chief Justice of the Florida Supreme Court issued an administrative order directing the Workgroup on Appellate Review of County Court Decisions to:

- Study whether the circuit courts should be uniformly required to hear appeals in panels and propose appropriate rule amendments, if necessary.
- Review a recommendation made by the Judicial Management Council's Workgroup on County Court Jurisdiction[7] and propose appropriate amendments to law or rule if necessary.
- Consider whether other changes to the process for appellate review of county court decisions would improve the administration of justice, in which case the Workgroup may propose any necessary revisions in the law and rules to implement the recommended changes.[8]

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[1] *See* art. V, ss. 1 – 6, Fla. Const.
[2] *See* art. V, s. 4(b)(1), Fla. Const.
[3] Article V, s. 6(b), Fla. Const. (stating that "[t]he county courts shall exercise the jurisdiction prescribed by general law." Under Article V, s. 5(b), the jurisdiction the circuit courts includes "original jurisdiction not vested in the county courts, and jurisdiction of appeals when provided by general law." Circuit courts also "have the power of direct review of administrative action prescribed by general law." *Id.*
[4] S. 26.012, F.S. (defining the jurisdiction of the circuit courts); s. 34.01, F.S. (defining the jurisdiction of the county courts).
[5] Ch. 2019-58, ss. 1 and 9, Laws of Fla.
[6] Ch. 2019-58, s. 1., Laws of Fla. (providing that the limitation on the appellate jurisdiction of circuit courts to matters where the amount in controversy is $15,000 or less is repealed on January 1, 2023).
[7] The Workgroup's recommendation was that any modification to the county court jurisdictional amount should include a provision allowing conflicts in circuit court appellate decisions within the same district to be certified to the DCA.

In October 2019, the Workgroup issued a report containing its recommendations. The Supreme Court agreed with the recommendation in part, indicating its support for legislation during the 2020 Regular Session to transfer circuit court appellate and related extraordinary writ authority to the DCAs. The Court also expressed a desire for the legislation to become effective no earlier than January 1, 2021, to allow adequate time for implementation.[9]

Authority to Define Appellate Court Jurisdiction

Although the Legislature has broad authority to define the jurisdiction of the circuit and county courts, its authority to define the jurisdiction of the DCAs is more limited. The State Constitution gives the:

- Circuit courts "jurisdiction over appeals when provided by general law."[10]
- DCAs jurisdiction to hear appeals that may be taken as a matter of right from final judgments or orders of trial courts, which are not directly appealable to the Supreme Court or a circuit court.[11]

Taken together, these provisions mean that the Legislature has the authority to determine the appellate jurisdiction of the circuit court; and that anything not designated by the Legislature as being within the circuit courts (or Supreme Court's) jurisdiction will be appealed to the DCA. In turn, if the Legislature removes a type of case from the appellate jurisdiction of a circuit court, the DCA will, by default, become the proper court to hear that type of appeal.

The DCAs also have the authority to:

- Hear appeals of certain interlocutory orders.
- Review administrative action as prescribed by general law.[12]

These provisions mean that a litigant has a right to only one appeal. As such, a litigant may appeal a final order of a county court or an administrative entity to a circuit court, but the litigant has no right to further appeal to a DCA.[13] The order may be reviewed by a DCA only by a writ of certiorari, which means that the DCA has the discretion to hear the case.[14] Moreover, a review by certiorari is much more limited in scope than a review by appeal.[15]

The certiorari jurisdiction of the DCAs is defined, not by statute, but by the Florida Rules of Procedure.[16] Similarly, the authority for a DCA to hear the appeal of an interlocutory order, which is a non-final order from a lower tribunal, is defined by court rules, not statutes. Because the Constitution divides the authority to define the appellate jurisdiction of the courts between the Supreme Court and the Legislature, expanding the appellate jurisdiction of the DCAs while reducing the appellate jurisdiction of the circuit courts requires cooperation between the judiciary and the Legislature.[17]

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[8] Supreme Court of Florida, In Re: Workgroup on Appellate Review of County Court Decisions, Administrative Order No. AOSC19-3, (Jan. 4, 2019), https://www.floridasupremecourt.org/content/download/425765/4589231/AOSC19-3.pdf (last visited Jan. 27, 2020).
[9] *See* Florida Bar News, *Justices Support Having DCAs Handle County Court Appeals*, https://www.floridabar.org/the-florida-bar-news/justices-support-having-dcas-handle-county-court-appeals/ (last visited Jan. 27, 2020).
[10] Art. V, s. 5(b), Fla Const.
[11] Art. V, s. 4(b)(1), Fla. Const.
[12] Art. V, s. 4(b), Fla. Const.
[13] *City of Deerfield Beach v. Valliant*, 419 So. 2d 624, 625 (Fla. 1982).
[14] *Id.*
[15] *See Haines City Cmty. Dev. v. Heggs*, 658 So. 2d 523, n.3. (Fla. 1995); *Broward County v. G.B.V. Int'l, Ltd.*, 787 So. 2d 838, 842 (Fla. 2001).
[16] Fla. R. Civ. P. 9.030(b)(2).
[17] For example, the Legislature, in many cases, can provide for the appeal of a final order of a county court to a DCA by eliminating the statutory authority for the appeal to be heard by a circuit court. By default, the appeal would have to be heard by a DCA. However, without changes to the court rules, interlocutory appeals from a county court case would continue to be heard by a circuit court that would not have jurisdiction to hear the appeal of a final order from the case.

Jurisdiction to Answer Certified Questions

Current law authorizes a county court to certify important questions to a DCA in a final judgment. The DCA has absolute discretion to answer the certified question or transfer the case back to the circuit court having appellate jurisdiction.[18]

Problem of Conflicting Circuit Court Appellate Decisions

Decisions of circuit courts in their appellate capacity are binding on all county courts within their circuit.[19] However, circuit courts are not bound by decisions of other circuit courts within their circuits. As a result, conflicting appellate decisions within a circuit court create instability in the law. County court judges and non-parties to the prior litigation do not know how or which appellate decisions to follow.[20]

When conflicting decisions are rendered by different panels of judges within the same DCA, the Florida Rules of Appellate Procedure permit the court to conduct an en banc proceeding,[21] which allows the full court to reconcile its potentially conflicting decisions.[22] In contrast, judicial circuits have no similar mechanism that enables them to reconcile their intra-circuit conflicting opinions. Moreover, a circuit court has no authorization to certify intra-circuit court conflicting opinions to a DCA for review.[23]

Legal Representation

The Office of the Attorney General is responsible for representing the state in all suits or prosecutions, in which the state may be a party or in anywise interested, in the Supreme Court and district courts of appeal.[24] For circuit and county court cases in which the state is a party, the State Attorney of the respective judicial circuit in which the case was filed is responsible for representing the state.[25]

The Public Defender shall represent any person determined to be indigent under s. 27.52, F.S.[26] The defense of indigent persons in cases appealed from a county or circuit court to a district court of appeal is the responsibility of the public defender office designated to handle appellate cases of all circuits within their respective appellate district.[27] If a Public Defender determines at any time during the representation of two or more defendants that counsel cannot be provided by their office due to a conflict of interest, the Office of Criminal Conflict and Civil Regional Counsel (RCC) of the appellate district is appointed to provide legal services to the indigent defendants.[28]

- First DCA:[29] Second Judicial Circuit Public Defender – RCC 1
- Second DCA:[30] Tenth Judicial Circuit Public Defender – RCC 2
- Third DCA:[31] Eleventh Judicial Circuit Public Defender – RCC 3
- Fourth DCA:[32] Fifteenth Judicial Circuit Public Defender – RCC 4
- Fifth DCA:[33] Seventh Judicial Circuit Public Defender – RCC 5

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[18] *See* ss. 34.017 and 35.065, F.S.
[19] *See Fieselman v. State*, 566 So. 2d 768, 770 (Fla. 1990).
[20] *See* Sebastien Rogers, *The Chasm in Florida Appellate Law: Intra-Circuit Conflicting Appellate Decisions*, Vol. 92, No. 4 Fla. Bar J. 52 (Apr. 2008).
[21] Fla. R. Civ. P. 9.331.
[22] *Id.*
[23] Rogers, *supra* n. 15.
[24] S. 16.01(4), F.S.
[25] S. 27.02(1), F.S.
[26] S. 27.51(1), F.S.
[27] S. 27.51(4), F.S.
[28] S. 27.511(5), F.S.
[29] First DCA: 1st, 2nd, 3rd, 4th, 8th, and 14th Judicial Circuits
[30] Second DCA: 6th, 10th, 12th, 13th and 20th Judicial Circuits.
[31] Third DCA: 11th and 16th Judicial Circuits.
[32] Fourth DCA: 15th, 17th and 19th Judicial Circuits.
[33] Fifth DCA: 5th, 7th, 9th and 18th Judicial Circuits.

Appellate Filing Fees

When a party appeals a case from circuit court to a district court of appeal, the filing fee is $400.[34] That fee is allocated:

- $50 to the State Courts Revenue Trust Fund;
- $250 to the General Revenue Fund; and
- $100 to the clerks of court.[35]

When a party appeals a case from county court to circuit court, the filing fee is $281.[36] That fee is allocated:

- $1 to the State Courts Revenue Trust Fund;
- $260 to the clerks of court; and
- $20 to the General Revenue Fund.[37]

Effect of Proposed Changes

HB 7059 transfers from the circuit courts to the DCAs the jurisdiction to hear appeals of decisions of county courts in civil and criminal cases. The bill is based on the recommendations of a recent report by the Judicial Management Council's Workgroup on Appellate Review of County Court Decisions.

Jurisdiction of the Circuit Court

The bill eliminates the authority of the circuit courts to hear appeals from county courts in:

- Criminal cases, by repealing s. 924.08, F.S., which provides that misdemeanor appeals from the county court are taken to the circuit court.
- Civil cases, by removing from s. 26.012, F.S., provisions stating that appeals of civil cases are to the circuit courts.

These modifications to ss. 924.08 and 26.012, F.S., will, by operation of the State Constitution, leave with the DCAs all jurisdiction of appeals from final orders of county courts in civil and criminal cases.[38] Circuit courts, however, will retain jurisdiction to hear appeals from final administrative orders of local code enforcement boards and to hear appeals and review other matters as expressly provided by law.

Certification of Questions of Importance

HB 7059 provides that a county court may certify important questions to a DCA only in a final judgment that is appealable to a circuit court. This change recognizes that there is no need for a county court to certify questions relating to matters that a litigant may appeal to a DCA as a matter of right.

The bill provides an effective date of January 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 26.012, F.S., relating to jurisdiction of circuit court.
Section 2: Amends s. 34.017, F.S., relating to certification of questions of district court of appeal.
Section 3: Amends s. 35.065, F.S., relating to review of judgment or order certified by county court to be of great public importance.
Section 4: Repeals s. 924.08, F.S., relating to courts of appeal.

[34] Ss. 28.241(2), 35.22(2)(a), F.S.
[35] Ss. 28.241(2), 35.22(5), F.S.
[36] Ss. 28.241(2), 44.108, F.S.
[37] S. 28.241(2), F.S.
[38] *See* art. V, s. 4(b)(1), Fla. Const.

Section 5: Provides an effective date of January 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The Revenue Estimating Conference determined the bill would increase appellate filing fee revenue for the state by a significant amount.

   The bill alters the appellate jurisdiction structure within the state court system. Based on the assumption that approximately 95% of the appellate cases would move from the circuit court to the DCA, the shift of appellate case filings would result in additional revenue from appellate filing fees in the amounts of approximately $0.4 M remitted to the General Revenue Fund, and $0.1 M remitted to the State Courts Revenue Trust Fund.[39]

2. Expenditures:

   The Office of the State Courts Administrator (OSCA) estimates the bill would increase DCA workload as a result of additional appellate filings, creating the need for $209,929 in recurring funds for an additional six OPS staff for six months in Fiscal Year 2020-2021.[40] Additional recurring funds in the amount of $208,710 will be needed to annualize the funding in Fiscal Year 2021-2022.

   Shifting appeals originating in county courts from the circuit courts to the DCA, would increase appellate workload on the Department of Legal Affairs by an indeterminate amount. State Attorney offices may have a reduction in workload related to appeals as a result of the jurisdictional shift.

   The bill may result in a shift of indigent defense appellate workload from the public defender's office in a judicial circuit to the designated appellate public defender's office of the corresponding district, to the extent that indigent defendants appeal county court cases to the DCA, that under current law would be appealed to the circuit court.

   The total fiscal impact of the bill is indeterminate due to lack of data to fully quantify the changes in judicial workload and other potential impacts of the bill on court operations.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The Revenue Estimating Conference determined the bill would decrease appellate filing fee revenue for the Clerks of the Court by a significant amount.

   The bill alters the appellate jurisdiction structure within the state court system. Based on the assumption that approximately 95% of the appellate cases would move from the circuit court to the DCA, the shift of appellate case filings would result in a reduction of $0.3 M of revenue from appellate filing fees remitted to the Clerk of Court Fine and Forfeiture Trust Fund.[41]

2. Expenditures:

   The bill would reduce appellate case filings for the Clerks of Court offices, and would reduce associated workload by an indeterminate amount.

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[39] Revenue Estimating Conference, *Impact Conference: HB 7059 Appellate Filing Fees,* February 14, 2020.
[40] Id.
[41] Id.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may necessitate changes in filing fees for certain appeals, which may have an indeterminate fiscal impact on the private sector.

D. FISCAL COMMENTS:

The bill would result in increased filing fees for a party which files for a notice of appeal from a county court. Under current law, a party filing a notice of appeal from a county court to a circuit court is required to pay a total of $281 of filing fees. The appellate jurisdiction shift from the circuit court to the DCA would result in a party being required to pay $400 in filing fees for a notice of appeal from a county court.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the jurisdiction of appellate courts; amending s. 26.012, F.S.; limiting the appellate jurisdiction of the circuit courts to appeals from final administrative orders of local code enforcement boards and other reviews and appeals expressly provided by law; amending s. 34.017, F.S.; authorizing a county court to certify a question to a district court of appeal in a final judgment that is appealable to a circuit court; amending s. 35.065, F.S.; authorizing a district court of appeal to review certain questions certified by a county court; repealing s. 924.08, F.S., relating to the jurisdiction of the circuit court to hear appeals from final judgments in misdemeanor cases; providing an effective date.

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

Section 1. Subsections (1) and (2) of section 26.012, Florida Statutes, are amended to read:

26.012 Jurisdiction of circuit court.—

(1) ~~Circuit courts shall have jurisdiction of appeals from county courts except:~~

~~(a) Appeals of county court orders or judgments where the~~

~~amount in controversy is greater than $15,000. This paragraph is repealed on January 1, 2023.~~

~~(b) Appeals of county court orders or judgments declaring invalid a state statute or a provision of the State Constitution.~~

~~(c) Orders or judgments of a county court which are certified by the county court to the district court of appeal to be of great public importance and which are accepted by the district court of appeal for review.~~ Circuit courts ~~shall~~ have jurisdiction of appeals from final administrative orders of local government code enforcement boards and of reviews and appeals as otherwise expressly provided by law.

(2) Circuit courts ~~They shall~~ have exclusive original jurisdiction:

(a) In all actions at law not cognizable by the county courts;

(b) Of proceedings relating to the settlement of the estates of decedents and minors, the granting of letters testamentary, guardianship, involuntary hospitalization, the determination of incompetency, and other jurisdiction usually pertaining to courts of probate;

(c) In all cases in equity including all cases relating to juveniles except traffic offenses as provided in chapters 316 and 985;

(d) Of all felonies and of all misdemeanors arising out of

the same circumstances as a felony which is also charged;

(e) In all cases involving legality of any tax assessment or toll or denial of refund, except as provided in s. 72.011;

(f) In actions of ejectment; and

(g) In all actions involving the title and boundaries of real property.

Section 2. Subsection (1) of section 34.017, Florida Statutes, is amended to read:

34.017 Certification of questions to district court of appeal.—

(1) A county court may ~~is permitted to~~ certify a question to the district court of appeal in a final judgment that is appealable to the circuit court if the question may have statewide application, and:

(a) Is of great public importance; or

(b) Will affect the uniform administration of justice.

Section 3. Section 35.065, Florida Statutes, is amended to read:

35.065 Review of judgment or order certified by county court to be of great public importance.—Pursuant to s. 34.017, a district court of appeal may review any order or judgment of a county court which is certified by the county court to be of great public importance.

Section 4. Section 924.08, Florida Statutes, is repealed.

Section 5. This act shall take effect January 1, 2021.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Appropriations Committee

Representative Fernandez-Barquin offered the following:

Amendment (with title amendment)

Between lines 74 and 75, insert:

Section 5. For the 2020-2021 fiscal year, the sum of $209,929 in recurring funds is appropriated from the State Courts Revenue Trust Fund to the State Courts System for additional support staffing needed to implement the provisions in this act.

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

Remove lines 15-16 and insert:

final judgments in misdemeanor cases; providing an appropriation; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7077 PCB CRJ 20-01 Postsentencing Forensic Analysis
SPONSOR(S): Criminal Justice Subcommittee, Grant, J.
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Criminal Justice Subcommittee	14 Y, 0 N	Hall	Hall
1) Appropriations Committee		Jones	Pridgeon
2) Judiciary Committee			

SUMMARY ANALYSIS

DNA is frequently collected at a crime scene and analyzed to assist in convicting or exonerating a suspect. DNA evidence may be collected from any biological material, such as hair, teeth, bones, skin cells, blood, semen, saliva, urine, feces, and other bodily substances. Other kinds of forensic analysis include fingerprint, footprint, tool mark, or tire print analysis; toxicology and blood alcohol analysis; fire debris, firearm, or explosive residue testing; microscopic hair analysis; and bite mark comparison. In some cases, science that was generally accepted at the time it was used in a criminal case has since been undermined by subsequent scientific advancements.

Florida law authorizes a person who has been tried and found guilty of committing a felony to examine physical evidence collected during the investigation of the crime for which he or she has been sentenced that may contain DNA which would exonerate the person or mitigate the sentence that he or she received. Generally, a court may grant a petition where identification is a genuinely disputed issue in the case, and the petitioner shows there is a reasonable probability that he or she would have been acquitted or would have received a lesser sentence if the DNA evidence had been admitted at trial. Currently the Florida Department of Law Enforcement (FDLE) or its designee must perform court-ordered DNA testing.

The National DNA Index System (NDIS) contains DNA profiles contributed by federal, state, and local participating forensic laboratories, enabling law enforcement to exchange and compare DNA profiles electronically, thereby linking a crime or a series of crimes to each other or to a known offender. FDLE administers Florida's statewide DNA database. The statewide database contains DNA samples submitted by persons convicted of or arrested for felony offenses and specified misdemeanor offenses.

HB 7077 expands the types of forensic analysis available to a petitioner beyond DNA testing and lowers the initial standard a petitioner must meet to gain access to forensic analysis. Under the bill, a petitioner must show that forensic analysis may result in evidence material to the identity of the perpetrator of, or accomplice to, the crime that resulted in the person's conviction, rather than having to show the evidence would exonerate the person or mitigate his or her sentence.

The bill authorizes a private laboratory to perform forensic analysis under specified circumstances at the petitioner's expense. If forensic analysis produces a DNA profile, FDLE must conduct a search of the statewide DNA database and must request NDIS to search the federal database. A database search may help a petitioner develop an alternative suspect for the crime for which he or she was convicted or, alternatively, may connect the petitioner to other unrelated or unsolved crimes. Finally, the bill authorizes a court to order a governmental entity, in possession of physical evidence claimed to be lost or destroyed, to search for the physical evidence and produce a report to the court, the petitioner, and the prosecuting authority.

The bill would have an indeterminate fiscal impact on state government. *See* Fiscal Analysis.

The bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

DNA Exonerations

Deoxyribonucleic acid (DNA) is hereditary material existing in the cells of all living organisms. A DNA profile may be created by testing the DNA in a person's cells.[1] Similar to fingerprints, a person's DNA profile is a unique identifier, except for identical twins, who have the exact same DNA profile.[2] DNA is frequently collected at a crime scene and analyzed to assist in convicting or exonerating a suspect. DNA evidence may be collected from any biological material, such as hair, teeth, bones, skin cells, blood, semen, saliva, urine, feces, and other bodily substances.[3] A DNA sample may be used to solve a current crime or a crime that occurred before DNA-testing technology.[4]

According to the National Registry of Exonerations (Registry), which tracks both DNA and non-DNA based exonerations, the misapplication of forensic science has contributed to 45 percent of wrongful convictions in the United States later resulting in an exoneration by DNA evidence.[5] Additionally, false or misleading forensic evidence was a contributing factor in 24 percent of all wrongful convictions nationally.[6] Data compiled through 2019 shows there have been 73 exonerations in Florida, and that false or misleading forensic evidence was a contributing factor to the person's wrongful conviction in 18 of those cases.[7] In some cases, science that was generally accepted at the time it was used in a criminal case has since been undermined by subsequent scientific advancements. Examples of scientific disciplines that have been discredited in recent years include:

- Microscopic hair analysis;[8]
- Arson investigation techniques;
- Comparative bullet lead analysis;[9] and
- Bite mark matching.[10]

DNA Databases

CODIS and NDIS

The most common form of DNA analysis used to match samples and test for identification in forensic laboratories analyzes only certain parts of DNA, known as short tandem repeats or satellite tandem

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[1] FindLaw, *How DNA Evidence Works*, https://criminal.findlaw.com/criminal-procedure/how-dna-evidence-works.html (last visited Feb. 5, 2020).
[2] *Id.*
[3] *Id.*
[4] *Id.*; Dr. Alec Jeffreys developed the DNA profiling technique in 1984.
[5] Innocence Project, *Overturning Wrongful Convictions Involving Misapplied Forensics,* http://www.innocenceproject.org/overturning-wrongful-convictions-invovling-flawed-forensics/ (last visited Feb. 5, 2020).
[6] *Id.*
[7] The National Registry of Exonerations, https://www.law.umich.edu/special/exoneration/Pages/browse.aspx?View={B8342AE7-6520-4A32-8A06-4B326208BAF8}&FilterField1=State&FilterValue1=Florida (last visited Feb. 5, 2020).
[8] Microscopic hair comparison involves comparing hair found at a crime scene with the hair of a defendant. *Id.*
[9] Comparative bullet lead analysis linked bullets found at a crime scene to bullets possessed by a suspect based on the belief that the bullet's lead composition was unique and limited to the originating batch. *Id.*
[10] Bite mark matching is the process of determining that a patterned injury left on a victim was made by human dentition and attempting to match the injury impression with the bite mark of the suspect. Liliana Segura and Jordan Smith, *Bad Evidence, Ten Years After a Landmark Study Blew the Whistle on Junk Science, the Fight Over Forensics Rages On*, The Intercept (May 5, 2019) https://theintercept.com/2019/05/05/forensic-evidence-aafs-junk-science/ (last visited Feb. 5, 2020).

repeats (STRs).[11] In the early 1990s, the Federal Bureau of Investigation (FBI) chose 13 STRs as the basis for a DNA identification profile, and the 13 STRs became known as the Combined DNA Index System (CODIS).[12] CODIS is now the general term used to describe the software maintained by the FBI and used to compare an existing DNA profile to a DNA sample found at a crime scene to identify the source of the crime scene sample.[13]

The DNA Identification Act of 1994 (DNA Act)[14] authorized the government to establish a National DNA Index, and in 1998 the National DNA Index System (NDIS) was established. NDIS contains DNA profiles contributed by federal, state, and local participating forensic laboratories,[15] enabling law enforcement to exchange and compare DNA profiles electronically, thereby linking a crime or a series of crimes to each other or to a known offender. A state seeking to participate in NDIS must sign a memorandum of understanding with the FBI agreeing to the DNA Act's requirements, including record-keeping requirements and other procedures. To submit a DNA record to NDIS, a participating laboratory must adhere to federal law regarding expungement[16] procedures, and the DNA sample must:

- Be generated in compliance with the FBI Director's Quality Assurance Standards;
- Be generated by an accredited and approved laboratory;
- Be generated by a laboratory that undergoes an external audit every two years to demonstrate compliance with the FBI Director's Quality Assurance Standards;
- Be from an acceptable data category, such as:
    - Convicted offender;
    - Arrestee;
    - Detainee;
    - Forensic case;
    - Unidentified human remains;
    - Missing person; or
    - Relative of a missing person.
- Meet minimum CODIS requirements for the specimen category; and
- Be generated using an approved kit.

Statewide DNA Database

In 1989, the Legislature established the Statewide DNA database (statewide database) to be administered by the Florida Department of Law Enforcement (FDLE), capable of classifying, matching, and storing analyses of DNA and other biological material and related data.[17] The statewide database contains DNA samples, including those:

- Submitted by persons convicted of or arrested for felony offenses and specified misdemeanor offenses; and
- Necessary for identifying missing persons and unidentified human remains, including samples voluntarily contributed by relatives of missing persons.[18]

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[11] Kelly Lowenberg, *Applying the Fourth Amendment when DNA Collected for One Purpose is Tested for Another*, 79 U. Cin. L. Rev. 1289, 1293 (2011), https://law.stanford.edu/wp-content/uploads/2011/11/APPLYING-THE-FOURTH-AMENDMENT-WHEN-DNA-COLLECTED-FOR-ONE-PURPOSE.pdf (last visited Feb. 5, 2020).
[12] *Id.*
[13] *Id.* at 1294.
[14] 42 U.S.C. § 14132.
[15] All 50 states, the District of Columbia, the federal government, the U.S. Army Criminal Investigation Laboratory, and Puerto Rico participate in NDIS. FBI Services, *Laboratory Services, Frequently Asked Questions on CODIS and NDIS,* https://www.fbi.gov/services/laboratory/biometric-analysis/codis/codis-and-ndis-fact-sheet (last visited Feb. 5, 2020).
[16] *See* 42 U.S.C. § 14132(d)(2)(A)(ii) (requiring states to expunge a DNA record when a charge is dismissed, results in an acquittal, or when no charge is filed).
[17] Ch. 89-335, Laws of Fla.
[18] S. 943.325(1), F.S.

All accredited local government crime laboratories in Florida have access to the statewide database in accordance with rules and agreements established by FDLE.[19] Local laboratories can access the statewide database through the CODIS, allowing for the storage and exchange of DNA records submitted by federal, state, and local forensic DNA laboratories.[20]

The statewide database may contain DNA data obtained from the following types of biological samples:

- Crime scene samples.
- Samples required by law to be obtained from qualifying offenders.[21]
- Samples lawfully obtained during the course of a criminal investigation, including those from deceased victims or deceased suspects.
- Samples from unidentified human remains.
- Samples from persons reported missing.
- Samples voluntarily contributed by relatives of missing persons.
- Other samples approved by FDLE.[22]

A qualifying offender is required to submit a DNA sample for inclusion in the statewide database if he or she is:

- Arrested or incarcerated in Florida; or
- On probation, community control, parole, conditional release, control release, or any other type of court-ordered supervision.[23]

An arrested offender must submit a DNA sample at the time he or she is booked into a jail, correctional facility or juvenile facility. An incarcerated person and a juvenile in the custody of the Department of Juvenile Justice must submit a DNA sample at least 45 days before his or her presumptive release date.[24] FDLE must retain all DNA samples submitted to the statewide database and such samples may be used for any lawful purpose.[25]

FDLE specifies database procedures to maintain compliance with national quality assurance standards to ensure that DNA records will be accepted into the NDIS. Results of any DNA analysis must be entered into the statewide database and may only be released to criminal justice agencies. Otherwise, the information is confidential and exempt from s. 119.07(1), F.S. and article I, s. 24(a), of the Florida Constitution.[26]

Post-sentencing DNA Testing

Defendants Sentenced After Trial

Florida law authorizes a person, who has been tried and found guilty of committing a felony, to petition a court to examine physical evidence collected during the investigation of the crime for which he or she has been sentenced that may contain DNA which would exonerate the person or mitigate the sentence that he or she received.[27] A sentenced defendant can file a petition for post-sentencing DNA testing any time after the judgment and sentence in his or her case becomes final.[28]

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[19] S. 943.325(4), F.S.
[20] S. 943.325(2), F.S.
[21] A "qualifying offender" is any person, convicted of a felony or attempted felony in Florida or a similar offense in another jurisdiction, or specified misdemeanors, who is: committed to a county jail; committed to or under the supervision of the Department of Corrections, including a private correctional institution; committed to or under the supervision of the Department of Juvenile Justice; transferred to Florida under the Interstate Compact on Juveniles or the Interstate Corrections Compact. S. 943.325(2)(g), F.S.
[22] S. 943.0325(6), F.S.
[23] S. 943.325(7), F.S.
[24] *Id.*
[25] *Id.*
[26] S. 943.325(14), F.S.
[27] S. 925.11(1)(a)1., F.S.
[28] S. 925.11(1)(a)2., F.S.

A petition for post-sentencing DNA testing must be made under oath, and include the following:

- A statement of the facts supporting the petition, including a description of the physical evidence containing DNA to be tested and, if known, the present location or last known location of the evidence and how it was originally obtained;
- A statement that the evidence was not previously tested for DNA or that the results of any previous DNA testing were inconclusive and that subsequent scientific developments in DNA testing techniques would likely produce a definitive result establishing that the petitioner is not the person who committed the crime;
- A statement that the sentenced defendant is innocent and how the DNA testing requested by the petition will exonerate the defendant of the crime for which he or she was sentenced or will mitigate the sentence he or she received;
- A statement that identification is a genuinely disputed issue in the case, and why it is an issue;
- Any other facts relevant to the petition; and
- A certification that a copy of the petition has been served on the prosecuting authority.[29]

A court must review the petition and deny it if it is insufficient. If the petition is sufficient, the prosecuting authority must respond within 30 days.[30] After reviewing the prosecuting authority's response, the court must either issue an order on the merits or set the petition for a hearing. If the court sets the petition for a hearing, it may appoint counsel to assist an indigent defendant, upon finding such assistance necessary.[31]

The court must make the following findings when ruling[32] on the petition:

- Whether the sentenced defendant has shown that the physical evidence that may contain DNA still exists;
- Whether the results of DNA testing of that physical evidence would be admissible at trial and whether there exists reliable proof to establish that the evidence has not been materially altered and would be admissible at a future hearing; and
- Whether there is a reasonable probability that the sentenced defendant would have been acquitted or would have received a lesser sentence if the DNA evidence had been admitted at trial.[33]

Defendants Sentenced After Entering a Plea

A defendant who entered a plea of guilty or nolo contendere to a felony offense before July 1, 2006, are eligible to petition for DNA testing based on the general eligibility requirements under s. 925.11, F.S. However, a defendant who entered a plea of guilty or nolo contendere to a felony offense on or after July 1, 2006, may only petition for post-sentencing DNA testing when:

- The facts on which the petition is based were unknown to the petitioner or his or her attorney at the time the plea was entered and could not have been ascertained through the exercise of due diligence; or
- The physical evidence for which DNA testing is sought was not disclosed to the defense prior to the entry of the petitioner's plea.[34]

Since July 1, 2016,[35] prior to the entry of a felony plea, the court must inquire of the defendant, the defense counsel, and the state regarding:

- The existence of known physical evidence that may contain DNA that could exonerate the defendant;

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[29] S. 925.11(2)(a), F.S.
[30] S. 925.11(2)(c), F.S.
[31] S. 925.11(2)(e), F.S.
[32] Any party adversely affected by the court's ruling on a petition for post-sentencing DNA testing has the right to appeal. S. 925.11(3), F.S.
[33] S. 925.11(2)(f), F.S.
[34] S. 925.12(1), F.S.
[35] Ch. 2006-292, Laws of Fla.

- Whether discovery in the case disclosed or described the existence of such physical evidence; and
- Whether the defense has reviewed the discovery.[36]

If no such evidence is known to exist, the court may accept the defendant's plea. If physical evidence containing DNA that could exonerate the defendant exists, the court may postpone the plea and order DNA testing to be conducted.[37]

Laboratory Testing

To preserve access to evidence, a governmental entity[38] must maintain any physical evidence collected in a case for which post-sentencing DNA testing may be requested. In a death penalty case, the evidence must be maintained for 60 days after execution of the sentence. In any other case, a governmental entity can dispose of the evidence if the term of the sentence imposed in the case has expired and the physical evidence is not otherwise required to be preserved by any other law or rule.[39]

FDLE or its designee must perform any DNA testing ordered under s. 925.11, F.S.[40] The sentenced defendant is responsible for the cost of testing, unless he or she is indigent, in which case, the state bears the cost. FDLE must provide the results of DNA testing to the court, the sentenced defendant, and the prosecuting authority. Fla. R. Crim. P. Rule 3.853 authorizes a court to order DNA testing by a private laboratory upon a petitioner's showing of good cause, when he or she can bear the cost of testing.[41]

Effect of Proposed Changes

HB 7077 amends s. 925.11, F.S., to expand access to post-sentencing testing of physical evidence. The bill expands the scope of current law to authorize post-sentencing testing to include other scientific techniques, in addition to DNA testing. Under the bill, a petitioner found guilty of committing a felony after trial or by entering a plea of guilty or nolo contendere before July 1, 2020, may petition for forensic analysis of physical evidence, rather than only DNA testing. "Forensic analysis" is defined as the process by which a forensic or scientific technique is applied to evidence or biological material to identify the perpetrator of, or accomplice to, a crime and includes, but is not limited to, DNA testing.

The bill lowers the initial standard a petitioner must meet to gain access to forensic analysis. Under the bill, the petitioner must show that forensic analysis may result in evidence material to the identity of the perpetrator of, or accomplice to, the crime that resulted in the person's conviction, rather than having to show the evidence would exonerate the person or mitigate his or her sentence.

Additionally, the bill amends the relevant petition requirements under s. 925.11, F.S., to reflect the new standards a petitioner must meet including:

- A statement that the evidence was not previously subjected to forensic analysis or that the results of any previous forensic analysis were inconclusive and that subsequent scientific developments in forensic analysis would likely produce evidence material to the identity of the perpetrator of, or accomplice to, the crime;
- A statement that the petitioner is innocent and how the forensic analysis requested by the petitioner may result in evidence that is material to the identity of the perpetrator of, or accomplice to, the crime; and

[36] Ss. 925.11(2) and (3), F.S.
[37] S. 925.11, F.S. Any postponement is attributable to the defendant for the purposes of speedy trial.
[38] A "governmental entity" includes, but is not limited to, any investigating law enforcement agency, the clerk of the court, the prosecuting authority, or FDLE. S. 925.11(4)(a), F.S.
[39] S. 925.11(4), F.S.
[40] S. 943.3251(1), F.S.
[41] Fla. R. Crim. P. Rule 3.853(c)(7).

- A statement that the petitioner will comply with any court order to provide a biological sample for the purpose of conducting requested forensic analysis and acknowledging such analysis could produce exculpatory evidence or evidence confirming the petitioner's identity as the perpetrator of, or accomplice to, the crime or a separate crime.

HB 7077 specifies post-sentencing forensic analysis eligibility criteria for defendants who entered a plea of guilty or nolo contendere to a felony, depending on the date the plea was entered. Defendants who entered a plea on or after July 1, 2006, but before July 1, 2020, may petition for DNA testing under the same standards currently required under s. 925.11, F.S. The bill maintains current criteria for these sentenced defendants because each had the benefit of the plea colloquy concerning the potential existence of exculpatory DNA evidence administered by the court since 2006.

Beginning July 1, 2020, the bill requires a court, prior to accepting a plea of guilty or nolo contendere to a felony, to perform a plea colloquy inquiring whether the defendant, defense counsel, or the state is aware of any physical evidence that, if subjected to forensic analysis, could produce evidence material to the identification of the perpetrator of, or accomplice to, the crime. As such, beginning July 1, 2020, a defendant entering a plea of guilty or nolo contendere to a felony will only be authorized to petition for post-sentencing forensic analysis when either:

- The facts on which the petition is predicated were unknown to the petitioner or the petitioner's attorney at the time the plea was entered and could not have been ascertained through the exercise of due diligence; or
- The physical evidence for which forensic analysis is sought was not disclosed to the defense by the state prior to the petitioner's plea.

When ruling on a petition for post-sentencing forensic analysis the court must make the following findings:

- Whether the petitioner has shown that the physical evidence, which may be subjected to forensic analysis, still exists;
- Whether the results of forensic analysis would be admissible at trial and whether reliable proof exists to establish that the evidence has not been materially altered and would be admissible at a future hearing; and
- Whether there is a reasonable probability the forensic analysis may result in evidence that is material to the identity of the perpetrator of, or accomplice to, the crime.

The bill authorizes a court to order a private laboratory, certified by the petitioner to meet specified accreditation requirements, to perform forensic analysis when:

- The prosecuting authority and the petitioner mutually select a private laboratory to perform the testing;
- The petitioner makes a sufficient showing that the forensic analysis:
    - Ordered by the court is of such a nature that FDLE or its designee cannot perform the testing; or
    - Will be significantly delayed because of state laboratory backlog.

If the forensic analysis ordered by the court includes DNA testing, and the resulting DNA sample meets statewide database submission requirements, FDLE must perform a DNA database search. A private laboratory ordered to conduct testing must cooperate with the prosecuting authority and FDLE to carry out the database search. The department must compare the submitted DNA profile to:

- DNA profiles of known offenders;
- DNA profiles from unsolved crimes; and
- Any local DNA databases maintained by a law enforcement agency in the judicial circuit where the petitioner was convicted.

The bill authorizes FDLE to maintain DNA samples obtained from testing ordered under ss. 925.11 or 925.12, F.S., in the statewide database. If the testing conducted complies with FBI requirements and

the data meets NDIS criteria, FDLE must request NDIS to search its database of DNA profiles using any profiles obtained from the court ordered testing. FDLE must provide the results of the forensic analysis and the results of any search of the national, statewide, and local DNA databases to the court, the petitioner, and the prosecuting authority. The petitioner and the state are authorized to use the information for any lawful purpose.

The bill authorizes a court to order a governmental entity, last known to possess evidence reported to be lost or destroyed in violation of law, to conduct a search and produce a report detailing:

- The nature of the search conducted.
- The date the search was conducted.
- The results of the search.
- Any records showing the physical evidence was lost or destroyed.
- The signature of the person supervising the search, attesting to the report's accuracy.

The report must be provided to the court, the petitioner, and the prosecuting authority in the case.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amending s. 925.11, F.S.; relating to post-sentencing DNA testing.
Section 2: Amending s. 925.12, F.S.; relating to DNA testing; defendants entering pleas.
Section 3: Amending s. 943.325, F.S.; relating to DNA database.
Section 4: Amending s. 943.3251, F.S.; relating to post-sentencing DNA testing.
Section 5: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will have an indeterminate fiscal impact on state government. The bill may increase the amount of post-sentencing forensic testing FDLE is ordered to perform thereby increasing state laboratories' workload. Additionally, if indigent defendants are successful in petitioning for post-sentencing analysis, the state may be responsible for increased testing costs. According to the FDLE, the impact to FDLE's workload and fiscal resources will be dependent on the number of items of evidence submitted to the FDLE crime laboratories, which cannot be known at this time.[42] However, the bill also authorizes private laboratory testing, at the petitioner's expense, which may decrease the impact to state laboratories.

   The Criminal Justice Impact Conference considered the bill on February 10, 2020, and determined the bill will have a negative indeterminate impact on prison beds (an unknown decrease). In Florida, 13 people have been exonerated or released from incarceration since 2000 as a result of post-conviction DNA testing.[43] It is unknown how the expansion of other types of forensic analysis

[42] Florida Department of Law Enforcement, 2020 FDLE Legislative Bill Analysis – HB 7077 (Feb. 5, 2020) (on file with the Justice Appropriations Subcommittee).
[43] The National Registry of Exonerations, https://www.law.umich.edu/special/exoneration/Pages/browse.aspx?View=%7bB8342AE7-6520-4A32-8A06-4B326208BAF8%7d&FilterField1=State&FilterValue1=Florida&FilterField2=DNA&FilterValue2=8%5FDNA (last visited Feb. 12, 2020).

available to a petitioner and restricting petitions to forensic analysis that could identify a perpetrator or accomplice to a crime will impact prison releases. Furthermore, such analysis could result in identifying multiple perpetrators or accomplices to a crime, causing an increase in prison beds.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None. The proposed bill does not appear to affect county or municipal governments.

2. Other:

Matters of practice and procedure in the state courts are solely the province of the Florida Supreme Court and may not be exercised by the Legislature.[44] However, the Court's exclusive rulemaking power is limited to rules governing procedural matters and does not extend to substantive rights.[45] The proposed bill and Fla. R. Crim. P. Rule 3.853 conflict regarding petition eligibility criteria and the required showing necessary to obtain a court order for private laboratory testing of physical evidence.

Where there is direct conflict between a statute and a court rule, the court must determine if the subject matter is procedural or substantive. Substantive law describes the duties and rights under our system of government and is the responsibility of the Legislature. Procedural law concerns the means or methods to enforce those duties and rights, and such authority is reserved to the judiciary.[46]

The proposed bill expands eligibility to petition, which may be considered substantive, and does not revise procedural requirements relating to time limitations or the right to a rehearing or an appeal. The Florida Supreme Court has held that where the subject matter of a rule is substantive rather than procedural law, and where the statute and rule conflict, the rule must either be revoked or amended to conform to the statute.[47] To the extent the provisions of the proposed bill conflicting with Fla. R. Crim. P. Rule 3.853 are substantive, the proposed bill may not violate separation of powers.

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[44] *Military Park Fire Control Tax Dis. No 4 v. DeMarois*, 407 So. 2d 1020 (Fla. 4th DCA 1981).
[45] *Boyd v. Becker*, 627 So. 2d 481 (Fla. 1993).
[46] *Benyard v. Wainwright*, 322 So.2d 473, 475 (Fla. 1975).
[47] *Id.*

B. RULE-MAKING AUTHORITY:

FDLE has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to postsentencing forensic analysis; amending s. 925.11, F.S.; providing definitions; authorizing specified persons to petition a court for postsentencing forensic analysis that may result in evidence of the identity of a perpetrator or accomplice to a crime; providing requirements for such a petition; requiring a court to make specified findings before entering an order for forensic analysis; requiring the forensic analysis to be performed by the Department of Law Enforcement; providing exceptions; requiring the department to submit a DNA profile meeting submission standards to certain DNA databases; requiring the results of the DNA database search to be provided to specified parties; authorizing a court to order specified persons to conduct a search for physical evidence reported to be missing or destroyed in violation of law; requiring a report of the results of such a search; amending s. 925.12, F.S.; authorizing specified defendants to petition for forensic analysis after entering a plea of guilty or nolo contendere; requiring a court to inquire of a defendant about specified information relating to physical evidence before accepting a plea; amending s. 943.325, F.S.;

authorizing certain samples obtained from postsentencing forensic analysis to be entered into the statewide DNA database; authorizing DNA analysis and results to be released to specified entities; amending s. 943.3251, F.S.; requiring the department to perform forensic analysis and searches of the statewide DNA database; providing an exception; requiring the results of forensic analysis and a DNA database search to be provided to specified entities; providing an effective date.

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

Section 1. Section 925.11, Florida Statutes, is amended to read:

925.11 Postsentencing forensic analysis ~~DNA testing~~.—

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

(a) "Forensic analysis" means the process by which a forensic or scientific technique is applied to evidence or biological material to identify the perpetrator of, or accomplice to, a crime. The term includes, but is not limited to, deoxyribonucleic acid (DNA) testing.

(b) "Petitioner" means a defendant who has been convicted of and sentenced for a felony.

(2)~~(1)~~ PETITION FOR EXAMINATION.—

(a)~~1.~~ A person who has entered a plea of guilty or nolo contendere to a felony before July 1, 2020, or who has been tried and found guilty of committing a felony and has been sentenced by a court established by the laws of the ~~this~~ state may petition that court to order the forensic analysis ~~examination~~ of physical evidence collected at the time of the investigation of the crime for which he or she has been sentenced that may result in evidence material to the identity of the perpetrator of, or accomplice to, the crime that resulted in the person's conviction ~~may contain DNA (deoxyribonucleic acid) and that would exonerate that person or mitigate the sentence that person received~~.

~~2. A person who has entered a plea of guilty or nolo contendere to a felony prior to July 1, 2006, and has been sentenced by a court established by the laws of this state may petition that court to order the examination of physical evidence collected at the time of the investigation of the crime for which he or she has been sentenced that may contain DNA (deoxyribonucleic acid) and that would exonerate that person.~~

(b) A petition for postsentencing forensic analysis ~~DNA testing~~ under paragraph (a) may be filed or considered at any time following the date that the judgment and sentence in the case becomes final.

(3)~~(2)~~ METHOD FOR SEEKING POSTSENTENCING FORENSIC ANALYSIS ~~DNA TESTING~~.—

(a) A ~~The~~ petition for postsentencing forensic analysis ~~DNA testing must be made under oath by the sentenced defendant~~ ~~and~~ must include the following:

1. A statement of the facts relied on in support of the petition, including a description of the physical evidence ~~containing DNA~~ to be tested and, if known, the present location or the last known location of the evidence and how it was originally obtained.~~;~~

2. A statement that the evidence was not previously subjected to forensic analysis ~~tested for DNA~~ or a statement that the results of any previous forensic analysis ~~DNA testing~~ were inconclusive and that subsequent scientific developments in forensic analysis ~~DNA testing techniques~~ would likely produce evidence material to ~~a definitive result establishing that~~ the identity of the perpetrator of, or accomplice to, ~~petitioner is not the person who committed~~ the crime.~~;~~

3. A statement that the petitioner ~~sentenced defendant~~ is innocent and how the forensic analysis ~~DNA testing~~ requested by the petitioner may result in evidence that is material to ~~petition will exonerate~~ the identity of the perpetrator of, or accomplice to, the ~~defendant of the crime for which the defendant was sentenced or will mitigate the sentence received by the defendant for that~~ crime.~~;~~

4. A statement that identification of the defendant is a genuinely disputed issue in the case, and why it is an issue.~~;~~

5. A statement that the petitioner will comply with any court order to provide a biological sample for the purpose of conducting requested forensic analysis and acknowledging such analysis could produce exculpatory evidence or evidence confirming the petitioner's identity as the perpetrator of, or accomplice to, the crime or a separate crime.

6.~~5.~~ Any other facts relevant to the petition.~~; and~~

7.~~6.~~ A certificate that a copy of the petition has been served on the prosecuting authority.

8. The petitioner's sworn statement attesting to the contents of the petition.

(b) Upon receiving the petition, the clerk of the court shall file it and deliver the court file to the assigned judge.

(c) The court shall review the petition and deny it if it is insufficient. If the petition is sufficient, the prosecuting authority shall be ordered to respond to the petition within 30 days.

(d) Upon receiving the response of the prosecuting authority, the court shall review the response and enter an order on the merits of the petition or set the petition for hearing.

(e) Counsel may be appointed to assist the petitioner ~~sentenced defendant~~ if the petition proceeds to a hearing and if the court determines that the assistance of counsel is necessary and makes the requisite finding of indigency.

(f) The court shall make the following findings when ruling on the petition:

1. Whether the petitioner ~~sentenced defendant~~ has shown that ~~the~~ physical evidence that may be subjected to forensic analysis ~~contain DNA~~ still exists.~~,~~

2. Whether the results of forensic analysis ~~DNA testing~~ of that physical evidence would be admissible at trial and whether there exists reliable proof to establish that the evidence has not been materially altered and would be admissible at a future hearing.~~, and~~

3. Whether there is a reasonable probability the forensic analysis may result in evidence that is material to the identity of the perpetrator of, or accomplice to, the crime ~~there is a reasonable probability that the sentenced defendant would have been acquitted or would have received a lesser sentence if the DNA evidence had been admitted at trial~~.

(g) If the court orders forensic analysis ~~DNA testing~~ of the physical evidence, the cost of such analysis ~~testing~~ may be assessed against the petitioner ~~sentenced defendant~~ unless he or she is indigent. If the petitioner ~~sentenced defendant~~ is indigent, the state shall bear the cost of the forensic analysis ~~DNA testing~~ ordered by the court, unless otherwise specified in paragraph (i).

(h) Except as provided in paragraph (i), any forensic analysis ~~DNA testing~~ ordered by the court shall be performed

~~carried out~~ by the Department of Law Enforcement or its designee, as provided in s. 943.3251.

(i) The court may order forensic analysis to be performed by a private laboratory and may assess the cost of such analysis against the petitioner when:

1. The prosecuting authority and the petitioner mutually select a private laboratory to perform the forensic analysis;

2. The petitioner makes a sufficient showing that the forensic analysis ordered by the court is of such a nature that it cannot be performed by the Department of Law Enforcement or its designee; or

3. The petitioner makes a sufficient showing that the forensic analysis will be significantly delayed because of state laboratory backlog.

(j) Before the court may order forensic analysis to be performed by a private laboratory, the petitioner shall certify to the court that the private laboratory is:

1. Accredited by an accreditation body that is a signatory to the International Accreditation Cooperation Mutual Recognition Agreement.

2. Designated by the Federal Bureau of Investigation as possessing an accreditation that includes DNA testing and the laboratory is compliant with Federal Bureau of Investigation quality assurance standards adopted in accordance with 34 U.S.C. s. 12591, if DNA testing is requested.

(k) If the court orders forensic analysis in the form of DNA testing and the resulting DNA sample meets statewide DNA database submission standards established by the Department of Law Enforcement, the department must perform a DNA database search. A private laboratory ordered to perform forensic analysis under paragraph (i) must cooperate with the prosecuting authority and the department for the purpose of carrying out this requirement.

1. The department shall compare any DNA profiles obtained from the testing to:

a. DNA profiles of known offenders maintained in the statewide DNA database under s. 943.325.

b. DNA profiles from unsolved crimes maintained in the statewide DNA database under s. 943.325.

c. Any local DNA databases maintained by a law enforcement agency in the judicial circuit in which the petitioner was convicted.

2. If the testing complies with Federal Bureau of Investigation requirements and the data meets national DNA index system criteria, the department shall request the national DNA index system to search its database of DNA profiles using any profiles obtained from the testing.

(l) ~~(i)~~ The results of the forensic analysis and the results of any search of the combined DNA index system and statewide and local DNA databases ~~DNA testing~~ ordered by the

court shall be provided to the court, the petitioner ~~sentenced defendant~~, and the prosecuting authority. The petitioner or the state may use the information for any lawful purpose.

(4)~~(3)~~ RIGHT TO APPEAL; REHEARING.—

(a) An appeal from the court's order on the petition for postsentencing DNA testing may be taken by any adversely affected party.

(b) An order denying relief shall include a statement that the petitioner ~~sentenced defendant~~ has the right to appeal within 30 days after the order denying relief is entered.

(c) The petitioner ~~sentenced defendant~~ may file a motion for rehearing of any order denying relief within 15 days after service of the order denying relief. The time for filing an appeal shall be tolled until an order on the motion for rehearing has been entered.

(d) The clerk of the court shall serve on all parties a copy of any order rendered with a certificate of service, including the date of service.

(5)~~(4)~~ PRESERVATION OF EVIDENCE.—

(a) Governmental entities that may be in possession of any physical evidence in the case, including, but not limited to, any investigating law enforcement agency, the clerk of the court, the prosecuting authority, or the Department of Law Enforcement shall maintain any physical evidence collected at the time of the crime for which a postsentencing testing of DNA

may be requested.

(b) In a case in which the death penalty is imposed, the evidence shall be maintained for 60 days after execution of the sentence. In all other cases, a governmental entity may dispose of the physical evidence if the term of the sentence imposed in the case has expired and no other provision of law or rule requires that the physical evidence be preserved or retained.

(c) In a case in which physical evidence requested for forensic analysis, last known to be in possession of a governmental entity, is reported to be missing or destroyed in violation of this section, the court may order the evidence custodian or other relevant official to conduct a physical search for the evidence. If a search is ordered, the governmental entity must produce a report containing the following information:

1. The nature of the search conducted.

2. The date the search was conducted.

3. The results of the search.

4. Any records showing the physical evidence was lost or destroyed.

5. The signature of the person who supervised the search, attesting to the accuracy of the contents of the report.

The report must be provided to the court, the petitioner, and the prosecuting authority.

Section 2. Section 925.12, Florida Statutes, is amended to read:

925.12 Forensic analysis ~~DNA testing~~; defendants entering pleas.—

(1) For defendants who have entered a plea of guilty or nolo contendere to a felony on or after July 1, 2006, but before July 1, 2020, a defendant may petition for postsentencing DNA testing under s. 925.11 under the following circumstances:

(a) The facts on which the petition is predicated were unknown to the petitioner or the petitioner's attorney at the time the plea was entered and could not have been ascertained by the exercise of due diligence; or

(b) The physical evidence for which DNA testing is sought was not disclosed to the defense by the state before ~~prior to~~ the entry of the plea by the petitioner.

(2) For defendants who have entered a plea of guilty or nolo contendere to a felony on or after July 1, 2020, a defendant may petition for postsentencing forensic analysis under s. 925.11 under the following circumstances:

(a) The facts on which the petition is predicated were unknown to the petitioner or the petitioner's attorney at the time the plea was entered and could not have been ascertained by the exercise of due diligence; or

(b) The physical evidence for which forensic analysis is sought was not disclosed to the defense by the state before the

entry of the plea by the petitioner.

(3) ~~(2)~~ For defendants seeking to enter a plea of guilty or nolo contendere to a felony on or after July 1, 2020 ~~July 1, 2006~~, the court shall inquire of the defendant and of counsel for the defendant and the state as to physical evidence ~~containing DNA~~ known to exist that, if subjected to forensic analysis, could produce evidence that is material to the identification of the perpetrator of, or accomplice to, the crime before ~~could exonerate the defendant prior to~~ accepting a plea of guilty or nolo contendere. If no such physical evidence ~~containing DNA that could exonerate the defendant~~ is known to exist, the court may proceed with consideration of accepting the plea. If such physical evidence ~~containing DNA that could exonerate the defendant~~ is known to exist, the court may postpone the proceeding on the defendant's behalf and order forensic analysis ~~DNA testing~~ upon motion of counsel specifying the physical evidence to be tested.

(4) ~~(3)~~ It is the intent of the Legislature that the Supreme Court adopt rules of procedure consistent with this section for a court, before ~~prior to~~ the acceptance of a plea, to make an inquiry into the following matters:

(a) Whether counsel for the defense has reviewed the discovery disclosed by the state and whether such discovery included a listing or description of physical items of evidence.

(b) Whether the nature of the evidence against the

defendant disclosed through discovery has been reviewed with the defendant.

(c) Whether the defendant or counsel for the defendant is aware of any physical evidence disclosed by the state for which forensic analysis could produce a result material to the identification of the perpetrator of, or accomplice to, the crime ~~DNA testing may exonerate the defendant~~.

(d) Whether the state is aware of any physical evidence for which forensic analysis could produce a result material to the identification of the perpetrator of, or accomplice to, the crime ~~DNA testing may exonerate the defendant~~.

(5) ~~(4)~~ It is the intent of the Legislature that the postponement of the proceedings by the court on the defendant's behalf under subsection (3) ~~(2)~~ constitute an extension attributable to the defendant for purposes of the defendant's right to a speedy trial.

Section 3. Subsections (6) and (14) of section 943.325, Florida Statutes, are amended to read:

943.325 DNA database.—

(6) SAMPLES.—The statewide DNA database may contain DNA data obtained from the following types of biological samples:

(a) Crime scene samples.

(b) Samples obtained from qualifying offenders required by this section to provide a biological sample for DNA analysis and inclusion in the statewide DNA database.

(c) Samples lawfully obtained during the course of a criminal investigation.

(d) Samples from deceased victims or suspects that were lawfully obtained during the course of a criminal investigation.

(e) Samples from unidentified human remains.

(f) Samples from persons reported missing.

(g) Samples voluntarily contributed by relatives of missing persons.

(h) Samples obtained from DNA analysis ordered under s. 925.11 or s. 925.12.

(i) ~~(h)~~ Other samples approved by the department.

(14) RESULTS.—The results of a DNA analysis and the comparison of analytic results shall be released only to criminal justice agencies as defined in s. 943.045 at the request of the agency or as required by s. 925.11 or s. 925.12. Otherwise, such information is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 4. Section 943.3251, Florida Statutes, is amended to read:

943.3251 Postsentencing forensic analysis and DNA database searches ~~DNA testing~~.—

(1) When a court orders postsentencing forensic analysis ~~DNA testing~~ of physical evidence~~,~~ pursuant to s. 925.11, the ~~Florida~~ Department of Law Enforcement, ~~or~~ its designee, or a private laboratory shall carry out the analysis. If the forensic

analysis produced a DNA sample meeting statewide DNA database submission standards, the department shall conduct a DNA database search ~~testing~~.

(2) The cost of forensic analysis and any database search ~~such testing~~ may be assessed against the petitioner ~~sentenced defendant~~, pursuant to s. 925.11, unless he or she is indigent.

(3) The results of postsentencing forensic analysis and any database search ~~DNA testing~~ shall be provided to the court, the petitioner ~~sentenced defendant~~, and the prosecuting authority.

Section 5. This act shall take effect July 1, 2020.