The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Richter, Chair
Senator Smith, Vice Chair

MEETING DATE: Tuesday, April 5, 2011
TIME: 10:15 a.m.—12:15 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Richter, Chair; Senator Smith, Vice Chair; Senators Alexander, Bennett, Bogdanoff, Fasano, Hays, Margolis, Negron, Oelrich, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 1072** Judiciary / Latvala (Identical H 951)	Recording of Real Property Documents; Establishes that certain electronic documents accepted for recordation are validly recorded. Provides legislative intent. Provides for prospective and retroactive application. JU 03/22/2011 Fav/CS BI 04/05/2011 Favorable BC	Favorable Yeas 9 Nays 0
2	**SB 1754** Garcia (Similar CS/H 1193)	Health Insurance; Prohibits a person from being compelled to purchase health insurance except under specified conditions. Specifies that the act does not prohibit the collection of certain debts. BI 03/22/2011 Temporarily Postponed BI 04/05/2011 Fav/CS HR RC	Fav/CS Yeas 7 Nays 2
3	**SB 1882** Garcia (Compare H 505)	Telemedicine Coverage; Requires health insurers, corporations, and health maintenance organizations issuing certain health policies to provide coverage for telemedicine services. Prohibits the exclusion of telemedicine cost coverage solely because the services were not provided face to face. Provides coverage under the state plan or a waiver for health home services provided to eligible individuals with chronic conditions, etc. BI 04/05/2011 Temporarily Postponed HR BC	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1836** Diaz de la Portilla (Identical H 1235)	Captive Insurance; Expands the kinds of insurance for which a captive insurer may seek licensure. Limits the risks that certain captive insurers may insure. Specifies requirements and conditions relating to a captive insurer's authority to conduct business. Requires that before licensure certain captive insurers must file or submit to the Commissioner of Insurance Regulation specified information, documents, and statements. Requires a captive reinsurance company to annually pay a specified tax amount, etc. BI 04/05/2011 Fav/CS BC	Fav/CS Yeas 10 Nays 0
5	**SB 1930** Bogdanoff (Compare CS/CS/H 967, CS/H 1411, S 1694)	Motor Vehicle Personal Injury Protection Insurance; Revises provisions relating to the contents of written reports of motor vehicle crashes. Requires that an application for licensure as a mobile clinic include a statement regarding insurance fraud. Authorizes the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity, etc. BI 03/29/2011 Temporarily Postponed BI 04/05/2011 Temporarily Postponed CJ BC	Temporarily Postponed
6	**SB 1694** Richter (Compare CS/CS/H 967, CS/H 1411, S 1930)	Motor Vehicle Personal Injury Protection Insurance; Provides that the circuit court has exclusive jurisdiction in actions involving challenges to arbitration decisions under the Florida Motor Vehicle No-Fault Law. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity. Provides that an insurer that requests an examination under oath in a manner that is inconsistent with the policy is engaging in an unfair and deceptive trade practice, etc. BI 03/29/2011 Not Considered BI 04/05/2011 Not Considered JU BC	Not Considered

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1500** Latvala (Identical H 1019, Compare CS/S 1972)	Foster Care Providers; Decreases the limits of liability and requisite insurance coverage for lead community-based providers and subcontractors. Provides immunity from liability for the Department of Children and Family Services for acts or omissions of a community-based provider or subcontractor, or the officers, agents, or employees thereof. BI 03/29/2011 Not Considered BI 04/05/2011 Not Considered CF JU BC	Not Considered

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1072
INTRODUCER:	Judiciary Committee and Senator Latvala
SUBJECT:	Recording of Real Property Documents
DATE:	March 31, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Maclure	Maclure	JU	**Fav/CS**
2.	Arzillo	Burgess	BI	**Favorable**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The committee substitute provides that a document that was or is submitted by electronic means to the clerk of court or county recorder and accepted for recordation is valid, even if the document was received and recorded prior to the Department of State adopting rules relating to the electronic recording of documents. These documents are also considered valid notwithstanding any defects in, deviations from, or the inability to demonstrate strict compliance with the statutory or regulatory framework in effect at the time of recordation. The bill specifies that it intends to clarify existing law and applies prospectively and retroactively. In this manner, the bill is designed to ratify the validity of documents submitted by electronic means to clerks of court or county recorders prior to the state's full implementation of electronic recording of real property documents.

This bill creates section 695.28, Florida Statutes.

II. Present Situation:

Uniform Real Property Electronic Recording Act: Background[1]

Real estate transactions are some of the oldest forms of transactions governed by law. Over the years as literacy and technology have evolved, these transactions have moved from being conducted symbolically to being recorded through the use of paper deeds, mortgages, and leases. Today, electronic communications have become more prevalent and in many situations have replaced paper. However, there are certain barriers to using electronic communications to carry on real estate transactions. Many states have enacted statute of fraud requirements that inhibit the use of electronic communications. In 1677, the "statute of frauds" was enacted to declare all contracts that were not in writing and signed by the parties to be unenforceable.[2] These requirements have made it more difficult to develop electronic alternatives to paper transactions that are equally enforceable. According to the Property Records Industry Association (PRIA), there are more than 3,600 recording jurisdictions nationwide. Although many of these jurisdictions have shown an interest in converting from paper recording systems to electronic systems, only a small number of jurisdictions have actually done so due to the lack of clear authority for them to do so.[3]

In 1999, the National Conference of Commissioners on Uniform State Laws (NCCUSL)[4] attempted to rectify this problem:

The first step to remedy this emerging problem took place in 1999 when the Uniform Law Commissioners promulgated the Uniform Electronic Transactions Act (UETA). This act adjusted statute of fraud provisions to include electronic "records" and "signatures" for the memorialization of all kinds of transactions, including basic transactions in real estate. It is possible to have sale contracts, mortgage instruments (in whatever form a jurisdiction uses) and promissory notes memorialized in electronic form with electronic signatures that will now be treated the equal of the same paper documents with manual signatures. This is the result of the wide-spread enactment of UETA and the subsequent enactment of the Electronic Signatures in Global and National Commerce Act (E-Sign) by Congress.

Real estate transactions, however, require another step not addressed by either UETA or E-Sign. Real estate documents must be recorded on public records to be effective. Recording takes place in most states in a county office devoted to keeping these records. Recording protects current interests in real estate by clarifying who holds those interests. The chain of title leading to the current title-holder, meaning the historic record of documents relating to transactions for a

[1] The information contained in this portion of the Present Situation of this bill analysis is from the Uniform Real Property Electronic Recording Act, as well as materials on the website of the National Conference of Commissioners on Uniform State Laws.
[2] BLACK'S LAW DICTIONARY (9th ed. 2009).
[3] National Conference of Comm'rs on Uniform State Laws, *Why States Should Adopt the Uniform Real Property Electronic Recording Act (URPERA), available at* http://uniformlaws.org/Act.aspx?title=Real%20Property%20Electronic%20Recording%20Act (follow the "Why States Should Adopt URPERA" link) (last visited Mar. 20, 2011) [hereinafter *Why States Should Adopt URPERA*].
[4] The NCCUSL is an organization that "provides states with non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of the law." National Conference of Comm'rs on Uniform State Laws, *Uniform Law Commission*, http://www.nccusl.org/ (last visited Mar. 20, 2011).

specific piece of real estate, establishes the marketability of that piece of real estate by the current owner of interests in it. The real estate records establish this chain of title. State law governs these local recording offices, and there are requirements in the law of every state relating to the originality and authenticity of paper documents that are presented for recording. These are themselves "statute of fraud" provisions that must be specifically adjusted before electronic recording may take place. Neither UETA nor E-Sign help.[5]

In 2004, the NCCUSL finalized and approved the Uniform Real Property Electronic Recording Act (URPERA), in order to provide clear authority to recording jurisdictions that electronic recording is acceptable. The URPERA:

- Maintains conceptual and definitional consistency between URPERA and UETA and E-Sign.
- Equates electronic documents and electronic signatures to original paper documents and manual signatures, so that any requirement for originality is satisfied by an electronic document.
- Provides greater clarity for the authority to implement electronic recording when compared with existing law.
- Designates a state entity or commission responsible for setting statewide uniform standards and requires it to set uniform standards that must be implemented in every recording office that elects to accept electronic documents.
- Establishes the factors that must be considered when a state entity formulates, adopts, and promotes standards for effective electronic recording.
- Allows for cross-storage of electronic and paper documents.[6]

Currently, 26 states, including the District of Columbia and the U.S. Virgin Islands, have enacted the URPERA, and three other states have introduced URPERA legislation in 2011.[7]

Electronic Recording of Real Property Documents in Florida

Florida adopted the Uniform Electronic Transaction Act (UETA) in 2000,[8] based on the act promulgated by the NCCUSL. The NCCUSL, the PRIA and the Electronic Financial Services Council, believed that UETA authorized the electronic creation, submission, and recording of electronic documents affecting real property.[9]

In 2007, Florida enacted the Uniform Real Property Electronic Recording Act, codified in s. 695.27, F.S.[10] Under the law, the Department of State (department) is required to consult with

[5] National Conference of Comm'rs on Uniform State Laws, *Uniform Real Property Electronic Recording Act Summary*, http://uniformlaws.org/ActSummary.aspx?title=Real%20Property%20Electronic%20Recording%20Act (last visited Mar. 20, 2011).
[6] *Why States Should Pass URPERA*, *supra* note 3.
[7] National Conference of Comm'rs on Uniform State Laws, *Real Property Electronic Recording Act: Enactment Status Map*, http://uniformlaws.org/Act.aspx?title=Real%20Property%20Electronic%20Recording%20Act (last visited Mar. 20, 2011).
[8] Chapter 2000-164, s. 1, Laws of Fla., codified in s. 668.50, F.S.
[9] *See* Property Records Industry Ass'n, *PRIA and EFSC on Electronic Recordation of Scanned Land Documents* (2004), *available at* http://www.pria.us/files/public/Committees/Real_Property_Law/URPERA/2004/FloridaSummary12204.pdf (last visited March 20, 2011)..
[10] Chapter 2007-233, s. 1, Laws of Fla.

the Electronic Recording Advisory Committee (committee)[11] to adopt standards to implement the URPERA in Florida. The department and committee are charged with keeping the standards and practices of county recorders in Florida in harmony with the standards and practices of other states' recording offices, and keeping the technology used by recorders in this state compatible with technology used in other states.[12] In doing this, s. 695.27(5)(e), F.S., directs the department, in consultation with the committee, to consider the following elements when adopting, amending, or repealing standards:

- The standards and practices of other jurisdictions;
- The most recent standards adopted by national standard-setting bodies, such as the PRIA;
- The views of interested persons and governmental officials and entities;
- The needs of counties by varying size, population, and resources; and
- Standards requiring adequate information security protection to ensure that electronic documents are accurate, authentic, adequately preserved, and resistant to tampering.

In May 2008, the department adopted rules pertaining to real property electronic recording.[13]

According to the Real Property, Probate and Trust Law Section of The Florida Bar, some of the state's clerks of court and county recorders began accepting electronic recordings prior to the adoption of URPERA, under the assumption that UETA authorized the use of electronic recordings, and others began accepting electronic documents before DOS adopted its rules governing electronic filing.[14]

Clerks of Court and County Recorders in Florida

Clerks of court and county recorders are required to maintain a variety of court and official records. Court records maintained by a clerk of court include:

> the contents of the court file, including the progress docket and other similar records generated to document activity in a case, transcripts filed with the clerk, documentary exhibits in the custody of the clerk, and electronic records, videotapes, or stenographic tapes of depositions or other proceedings filed with the clerk, and electronic records, videotapes, or stenographic tapes of court proceedings . . . .[15]

Court clerks also serve as county recorders.[16] Official records maintained by the clerk of court, acting as the county recorder, include recorded judgments, deeds, mortgages, claims of liens, death certificates, certificates of discharge from military service, maps, and other records.[17]

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[11] The committee terminated on July 1, 2010. Section 695.27(5)(f), F.S.
[12] Section 695.27(5)(e), F.S.
[13] See Rules 1B-31.001 and 1B-31.002, F.A.C.
[14] Real Property, Probate and Trust Law Section, The Florida Bar, *Legislative Position Request Form* (2009) (on file with the Senate Committee on Judiciary).
[15] Fla. R. Jud. Admin. 2.420(b)(1)(A).
[16] Section 28.222, F.S.
[17] *Id.*

III. Effect of Proposed Changes:

Electronic Recording of Real Property Documents

This committee substitute creates s. 695.28, F.S., to provide that a document that is entitled to be recorded and that was or is submitted by electronic means and accepted by the clerk of court or county recorder for recordation is valid, even if the document was received and recorded before the Department of State (department) adopted rules relating to the electronic recording of documents. These documents are also considered valid notwithstanding any defects in, deviations from, or the inability to demonstrate strict compliance with the statutory or regulatory framework in effect at the time of recordation. The bill specifies that the newly created section of law does not alter the duty of the clerk of court or county recorder to comply with s. 695.27, F.S., or the rules adopted pursuant to that section.

The bill states that it is intended to clarify existing law and applies prospectively and retroactively. Some clerks of court and county recorders began accepting electronic recordings prior to the department adopting rules to implement the Uniform Real Property Electronic Recording Act (URPERA). According to the Real Property, Probate and Trust Law Section of the Florida Bar:

> The intent of the statute, of the rule and of the parties to the Electronic Documents was that they be valid, binding, validly filed and to provide constructive notice notwithstanding timing differences or the mechanism for converting the physical signature into an electronic signature.
>
> Because of the importance of a stable and certain record title and land conveyance system, this bill retroactively and prospectively ratifies the validity of all such electronic documents submitted to and accepted by a county recorder for recordation, notwithstanding those types of possible technical defects.[18]

Except as otherwise provided, the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[18] Real Property, Probate and Trust Law Section, The Florida Bar, *White Paper: Bill Curing Certain Defects as to Electronic Documents and Electronically Recorded Documents* (2008) (on file with the Senate Committee on Judiciary).

D. Other Constitutional Issues:

This bill provides that it is the Legislature's intent to clarify existing law and that the provisions of the bill apply prospectively and retroactively. Retroactive operation is disfavored by courts and generally "statutes are prospective, and will not be construed to have retroactive operation unless the language employed in the enactment is so clear it will admit of no other construction."[19] The Florida Supreme Court has articulated four issues to consider when determining whether a statute may be retroactively applied:

- Is the statute procedural or substantive?
- Was there an unambiguous legislative intent for retroactive application?
- Was a person's right vested or inchoate?
- Is the application of the statute to these facts unconstitutionally retroactive?[20]

The general rule of statutory construction is that a procedural or remedial statute may operate retroactively, but that a substantive statute may not operate retroactively without clear legislative intent. Substantive laws either create or impose a new obligation or duty, or impair or destroy existing rights, and procedural laws enforce those rights or obligations.[21] It appears that the bill is clarifying existing law, rather than creating new statutory rights, duties, or obligations.

Additionally, the bill makes it clear that it is the Legislature's intent to apply the law retroactively. "Where a statute expresses clear legislative intent for retroactive application, courts will apply the provision retroactively."[22] A court will not follow this rationale, however, if applying a statute retroactively will impair vested rights, create new obligations, or impose new penalties.[23] This bill does not appear to do any of these things. Accordingly, to that extent, the retroactive nature of the bill does not appear to pose significant constitutional concerns.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

[19] Norman J. Singer and J.D. Shambie Singer, *Prospective or retroactive interpretation*, 2 SUTHERLAND STATUTORY CONSTR. s. 41:4 (6th ed. 2009).
[20] *Weingrad v. Miles*, 29 So. 3d 406, 409 (Fla. 3d DCA 2010) (internal citations omitted).
[21] *See Alamo Rent-A-Car, Inc. v. Mancusi*, 632 So. 2d 1352, 1358 (Fla. 1994); *In re Rules of Criminal Procedure*, 272 So. 2d 65, 65 (Fla. 1972).
[22] *Weingrad*, 29 So. 3d at 410.
[23] *Id*. at 411.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Judiciary on March 22, 2011:
The committee substitute:

- Removes from the original bill the provisions requiring certain governmental liens to be recorded in the official records and expanding the current mechanism under which a person can claim that property is a homestead and exempt from forced sale;
- Removes the provisions making conforming changes to the Uniform Real Property Electronic Recording Act and extending the existence of the Electronic Recording Advisory Committee to July 1, 2013; and
- Specifies that the changes made by the bill apply prospectively, as well as retroactively.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/05/2011	.	
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The Committee on Banking and Insurance (Oelrich) recommended the following:

Senate Amendment (with title amendment)

Delete lines 11 - 12
and insert:
Section 1. Section 624.24, Florida Statutes, is created to read:
624.24 Prohibition against requiring the purchase of health insurance; exceptions.—

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete line 2

and insert:

An act relating to health insurance; creating s. 624.24, F.S.; prohibiting a

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1754
INTRODUCER:	Banking and Insurance Committee and Senator Garcia
SUBJECT:	Health Insurance
DATE:	April 5, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.			HR	
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill provides that a person may not be compelled to purchase health insurance, except as a condition of:

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

The bill also provides that this would not prohibit the collection of debts lawfully incurred for health insurance.

This bill creates section 624.24, Florida Statutes.

II. Present Situation:

The Federal Patient Protection and Affordable Care Act
On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, (PPACA), P.L. 111-148, as amended by the Reconciliation Act, P.L. 111-152. The PPACA is a broad-based, national approach designed to reform various aspects of the health care system including access and affordability of coverage.

The PPACA establishes new requirements on individuals, employers, and health plans; restructures the private health insurance market; and creates exchanges for individuals and employers to obtain coverage. An exchange is not an insurer; however, it would provide eligible individuals and businesses with access to insurers' plans.

The PPACA expands the Medicaid program in 2014 to include nonelderly, nonpregnant individuals with income below 133 percent of the federal poverty level who were previously ineligible for Medicaid. Also in 2014, some individuals who do not qualify for Medicaid, but who meet other requirements, will be provided with premium tax credits and cost-sharing subsidies to help pay for the premiums and out-of-pocket costs of health plans offered through an exchange.

The PPACA requires most U.S. citizens and legal residents to obtain health insurance by January 1, 2014, [1] or potentially pay a penalty for noncompliance. A taxpayer is exempt from the penalty if the individual has a household income below a certain threshold, is a member of an Indian tribe, or has a religious objection to purchasing health insurance. An individual who fails to maintain coverage is required to pay an annual tax penalty of the greater of $95 for each household member (up to $285), or 1 percent of household income in 2014, $325 or 2 percent of household income in 2015, and $695 or 2.5 percent of income in subsequent years. The penalty for an entire family is capped at $2,250. The applicable penalty for dependents under the age of 18 is one-half the amount for adults.

If an individual that is subject to the penalty fails to pay the penalty, the Internal Revenue Service can attempt to collect funds by reducing the amount of an individual's tax refund in the future. However, individuals that fail to pay the penalty will not be subject to any criminal prosecution for such failure.

Congressional Authority and Constitutionality

Commerce Clause (U.S. Const. Art. I, Sec. 8, Clause 3)
Congress has the power to regulate interstate commerce, including local matters and issues that "substantially affect" interstate commerce. Proponents of reform assert that although health care delivery is local, the sale and purchase of medical supplies and health insurance occurs across state lines, thus regulation of health care is within Commerce Clause authority. Arguing in support of an individual mandate, proponents point to insurance market destabilization caused by the large uninsured population as reason enough to authorize Congressional action under the

[1] Section 1501(b) as amended by section 101006 (b) of P.L. 111-148 and by s. 1002 of P.L. 111-152.

Commerce Clause.[2] Opponents suggest that the decision not to purchase health care coverage is not a commercial activity and cite to *United States v. Lopez*[3] which held that Congress is prohibited from "…unfettered use of the Commerce Clause authority to police individual behavior that does not constitute interstate commerce."[4]

The Tenth Amendment and the Anti-Commandeering Doctrine (U.S. Const. Amend. 10)
The Tenth Amendment reserves to the states all power that is not reserved expressly for the federal government in the U.S. Constitution. Opponents of federal reform assert that the individual mandate violates federalism principles because the U.S. Constitution does not authorize the federal government to regulate health care. They argue, "…state governments – unlike the federal government – have greater, plenary authority and police powers under their state constitutions to mandate the purchase of health insurance."[5] Further, opponents argue that the state health insurance exchange mandate may violate the anti-commandeering doctrine, which prohibits the federal government from requiring state officials to carry out onerous federal regulations.[6] Proponents for reform suggest that Tenth Amendment jurisprudence only places wide and weak boundaries around Congressional regulatory authority to act under the Commerce Clause.[7]

State Legislative Actions

State Legislation Implementing PPACA
As of September 27, 2010, at least 25 states have enacted or adopted legislation or taken official action to form a committee, task force, or board concerning health reform implementation.[8] Additionally, at least 14 governors have issued executive orders to begin the process of health reform implementation.[9]

State Legislation Opposing PPACA
In response to the federal health care reform, state legislators in at least 40 states have filed legislation to limit, alter, or oppose certain state or federal action, including single-payer provisions and mandates that would compel the purchase of health care insurance.[10] In 30 of the states, the legislation includes a proposed constitutional amendment by ballot.[11]

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[2] Jack Balkin, *The Constitutionality of the Individual Mandate for Health Insurance*, N. Eng. J. Med. 362:6, at 482 (February 11, 2010).
[3] 514 U.S. 549 (1995).
[4] Peter Urbanowicz and Dennis G. Smith, *Constitutional Implications of an 'Individual Mandate' in Health Care Reform*, The Federalist Society for Law and Public Policy, at 4 (July 10, 2009).
[5] *Id*.
[6] Matthew D. Adler, *State Sovereignty and the Anti-Commandeering Cases*, The Annals of the American Academy of Policy and Social Science, 574, at 158 (March 2001).
[7] Hall, *supra* note 25, at 8-9.
[8] National Conference of State Legislators, *State Actions to Implement Federal Health Reform*, Nov. 22, 2010, available at http://www.ncsl.org/default.asx?tabid=20231#Legislative (last visited Jan. 3, 2011).
[9] *Id*.
[10] National Conference of State Legislatures, *State Legislation and Actions Challenging Certain Health Reforms, 2010*, Dec. 18, 2010, *available at* http://www.ncsl.org/?tabid=18906 (last visited Jan. 3, 2011).
[11] *Id*.

Florida Insurance Coverage Requirements

Florida law does not require state residents to maintain health insurance coverage. However, Florida law does require drivers to carry Personal Injury Protection (PIP) insurance,[12] which includes specified medical benefits, as a condition of registering a motor vehicle.[13] Florida law also requires employers to secure the payment of workers' compensation. Employers secure workers' compensation coverage by purchasing insurance or meeting the requirements to self-insure.[14] Workers' compensation insurance provides certain medical and indemnity benefits.[15]

III. Effect of Proposed Changes:

The bill creates s. 624.24, F.S., and provides that a person may not be compelled to purchase health insurance, except as a condition of:

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

The bill also provides that the act does not prohibit the collection of debts lawfully incurred for health insurance.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Florida and 25 other states brought an action in the United States District Court for the Northern District of Florida challenging the constitutionality of PPACA. On January 31, 2011, Judge

[12] Section 627.736, F.S.
[13] Section 320.02(5)(a), F.S.
[14] Section 440.38, F.S.
[15] Sections 440.13, 440.15, and 440.16, F.S.

Roger Vinson found the Act unconstitutional.[16] The court rejected the argument by the United States that the individual mandate is a tax and made it clear that he agreed with the plaintiff's argument that the power the individual mandate seeks to harness "is simply without precedent." On March 3, 2011, Judge Vinson granted a stay of his order on the condition that the federal government seek an immediate appeal and seek an expedited review. The federal government filed the appeal and motion for expedited review to the United State Court of Appeal for the Eleventh Circuit on March 8, 2011.[17] Florida and the other plaintiffs have filed a motion requesting a more condensed briefing and oral argument schedule than requested by the federal government. The Eleventh Circuit responded on March 11, 2011 setting the briefing schedule beginning on April 4, 2011 and ending May 25, 2011.[18]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

Banking and Insurance Committee on April 5, 2011:

Designates section of Florida Statutes that is being created.

[16] State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.).
[17] Case No. 11-11021-HH.
[18] State of Fla., et al. v. U.S. Dept. of Health & Human Serv., Nos. 11-11021-HH & 11-11067-HH, Order on Appellants' Mtn. to Expedite Appeal (11th Cir. March 11, 2011).

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Coverage for telemedicine services.—Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, and each health maintenance organization providing a health care plan for health care services, may provide coverage for the cost of such health care services provided by an in-network health care provider through telemedicine services, as provided in this

283978

section.

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

(a) "Adverse decision" means a determination that the use of telemedicine services rendered or proposed to be rendered by an in-network provider is not covered under the policy, contract, or plan.

(b) "In-network provider" means a licensed health care provider who has contracted with an insurer or a health maintenance organization to provide services to the insurer's policyholders or the subscribers of the health maintenance organization.

(c) "Telemedicine services," as it pertains to the delivery of health care services by an in-network provider, means interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, including home health video conferencing and remote patient monitoring. The term does not include an audio-only telephone, electronic mail message, or facsimile transmission, or radiology services performed by a health care practitioner not licensed in this state.

(d) "Utilization review" means a review to determine the appropriateness of telemedicine services or whether coverage of the delivery of telemedicine services rendered or proposed to be rendered by an in-network health care provider is required, if the determination is made in the same manner as those determinations that are made for the treatment of any other illness, condition, or disorder covered under the policy, contract, or plan.

(2) An insurer or health maintenance organization may not

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exclude a service from coverage solely because the service is provided through telemedicine services rather than face-to-face consultation or contact between an in-network health care provider and a patient.

(3) An insurer or health maintenance organization is not required to reimburse the telemedicine provider or the consulting provider for technological fees or costs for the provision of telemedicine services; however, an insurer or health maintenance organization must reimburse the telemedicine provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services according to the terms of the contract between the in-network provider and the insurer or health maintenance organization.

(4) An insurer or health maintenance organization may offer a health care plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services.

(5) An insurer or health maintenance organization may not impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, contract, or plan, and may not impose upon any person receiving benefits under this section any copayment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, which is not equally imposed upon all terms and services covered under the policy, contract, or plan.

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(6) This section applies to insurance policies, contracts, and plans delivered, issued for delivery, reissued, renewed, or extended in this state on and after October 1, 2011.

(7) This section does not apply to short-term travel, accident-only, limited benefit or specified disease, disability income, or long-term care policies designed for issuance to persons who are eligible for Medicare coverage under Title XVIII of the Social Security Act or any other similar coverage under state or federal governmental plans.

(8) This section does not preclude any insurer or health maintenance organization providing coverage for telemedicine services under an insurance policy, contract, or plan from undertaking a utilization review. After making an adverse decision, an insurer or health maintenance organization shall notify the covered individual and the individual's health care provider.

Section 2. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to telemedicine coverage; authorizing health insurers and health maintenance organizations issuing certain health policies to provide coverage for telemedicine services; providing definitions; prohibiting the exclusion of telemedicine cost coverage solely because the services were not provided

face to face; specifying conditions under which an insurer or health maintenance organization must reimburse a telemedicine provider for certain fees and costs; authorizing an insurer or health maintenance organization to offer a health care plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services; prohibiting the imposition of certain dollar and durational coverage limitations or copayments, coinsurance, or deductibles on telemedicine services unless imposed equally on all terms and services; providing for application of the act; providing for certain exclusions; providing that an insurer or health maintenance organization that provides coverage for telemedicine services under an insurance policy, contract, or plan is not precluded from undertaking a utilization review; providing effective dates.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1882
INTRODUCER:	Senator Garcia
SUBJECT:	Telemedicine Coverage
DATE:	April 3, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson/Matiyow	Burgess	BI	**Pre-meeting**
2.			HR	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1882 requires insurers, HMOs, and self-insured corporations issuing for health care policies, contracts or plans to provide reimbursement for covered services rendered utilizing telemedicine. Medical services rendered using telemedicine must be reimbursed on the same basis that such services are reimbursed when provided through traditional means and may not be subject to a different deductible, copayment, or coinsurance requirement than generally applies to such medical services. Additionally, the health care insurance policy or contract or plan cannot impose different annual or lifetime dollar maximum limits to telemedicine services than are equally imposed upon all terms and services covered by the policy, contract or plan. The bill also requires the state group health insurance plan to provide medical assistance to eligible individuals with chronic conditions as required by the Home Health Model of the Patient Protection Act (42 U.S.C. s. 1396w-4).

This bill creates undesignated sections of the Florida Statutes.

II. Present Situation:

Telemedicine

Telemedicine utilizes various advances in communication technology to provide healthcare services through a variety of electronic mediums. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided though Telemedicine include:

- **Specialist referral services** typically involves of a specialist assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later.
- **Patient consultations** using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan. This might originate from a remote clinic to a physician's office using a direct transmission link or may include communicating over the Web.
- **Remote patient monitoring** uses devices to remotely collect and send data to a monitoring station for interpretation. Such telemedicine applications might include specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients.

Telemedicine Services in Florida

The Children's Medical Services Network (CMS Network) provides specified telemedicine services under Florida's 1915(b) Medicaid Managed Care Waiver in compliance with federal and state regulations. Authorized CMS Network telemedicine services include certain evaluation and consultation services already covered by the Medicaid state plan. In December 2010, Florida Medicaid submitted a state plan amendment to the federal Centers for Medicare and Medicaid Services CMS) to allow for the provision of specified physician, dental, mental health, and substance abuse treatment telemedicine services. The waiver has been requested because Medicaid reimburses only the physician dentist rendering services using telemedicine, not the provider who is with the patient. Current regulations require that the physician must be physically present in the same room as the patient during the visit, which essentially requires a second, uncompensated physician to be present with the patient. This requirement must also be met for Medicaid to pay for services provided to Medicaid eligible patients while in a Medicare or Medicaid certified facility. Representatives from the Agency for Health Care Administration expect approval of the Medicaid waiver.

Florida law allows the Florida Board of Medicine to establish by rule standards of practice and standards of care for particular practice settings, including, but not limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedure manuals.[1] The board has adopted rule 64B8-9.014 "Standards for Telemedicine Prescribing Practice." The rule prohibits a telemedicine doctor from prescribing medications based solely on an online questionnaire. The rule allows a doctor to prescribe using telemedicine if they do so based on a patient's documented medical history and physical examination, properly filed and maintained records, and after discussing the potential risks of treatment with the patient. The rule exempts emergency situations. Doctors that have prior direct contact with a patient may be involved in treatment when a telemedicine doctor is involved as well for purposes of rendering a second opinion on prescriptions and sharing the duties of caring for a patient or handling patient records.

Some of the major Florida based healthcare providers who provide telemedicine services, include:

[1] s. 458.331(1)(v), F.S.

- **The University of Florida,** which operates the Center for Telehealth and Healthcare Communications (CTHC) that provides training and education for telemedicine services to health care providers.
- **The University of Miami,** which offers patients telemedicine service at their Miller School of Medicine.
- **The Mayo Clinic in Florida,** which has a telemedicine stroke program. According to their website doctors at the Florida Mayo Clinic have performed more than 60 stroke telemedicine consultations.

III. Effect of Proposed Changes:

Section 1. Creates an undesignated statutory section requiring insurers, HMOs, and self-insured corporations issuing for health care policies, contracts or plans to provide reimbursement for covered services rendered utilizing telemedicine.

Telemedicine services are defined as the delivery of health care services using interactive video, audio, or other electronic media used for purposes of diagnosis, consultation, or treatment, including home health video conferencing and remote patient monitoring. Telemedicine services do not include audio-only telephone, electronic mail message, or facsimile transmission.

Medical services rendered using telemedicine must be reimbursed on the same basis that such services are reimbursed when provided through traditional means. Health care services may not be excluded from coverage solely because it is provided through telemedicine. Telemedicine services may not be subject to a different deductible, copayment, or coinsurance requirement than applies to such services generally. Additionally, the health care insurance or contract cannot impose different annual or lifetime dollar maximum limits to telemedicine services than are equally imposed upon all terms and services covered under the health care policy, contract, or plan. However, reimbursement need not be provided for the technological fees or costs associated with providing telemedicine services. The insurer, corporation, or HMO may continue conduct a utilization review. If coverage for telemedicine services is denied, a utilization review must be conducted upon the request of the covered individual or that person's health care provider.

The requirement to provide telemedicine services applies to insurance policies, contracts, and plans issued, reissued, or extended on or after July 1, 2011, if a contract term is changed or a premium adjustment is made. All policies, contracts, and plans must provide coverage for telemedicine services no later than July 1, 2012. The requirement to provide reimbursement for telemedicine services does not apply to short-term travel, accident only, limited or specified disease, individual conversion policies, or contracts designed for Medicare-eligible persons and other similar coverage under state or federal government plans (thus exempting Medicaid plans).

Section 2. Creates an undesignated section of statute requiring the state group health insurance plan to provide medical assistance to eligible individuals with chronic conditions as required by the Home Health Model of the Patient Protection Act (42 U.S.C. s. 1396w-4). The constitutionality of the Patient Protection Act is currently in question.

Section 3. The act is effective July 1, 2011, except as otherwise provided in the act.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

United States District Judge Roger Vinson has ruled that the Affordable Care Act is unconstitutional. Should this ruling be upheld, 42 U.S.C. s. 1396w-4 would be repealed, thereby invalidating Section 2 of the bill.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires certain insurers, corporations, and HMOs to provide coverage for health care services rendered via telemedicine. It may expand access to care in certain areas such as rural areas. The requirement to provide such services may impact the cost of these health plans.

Insurers, self-insuring corporations, and HMOs may incur additional costs amending their policy and contract forms comply with the bill's requirement to provide reimbursement for telemedicine services.

The bill does not contain requirements regarding the types of providers that may render services through telemedicine. There is a danger that telemedicine techniques may create new avenues for medical insurance fraud as fraudulent medical providers located outside the state may attempt to bill for telemedicine services.

C. Government Sector Impact:

Representatives from the Agency for Health Care Administration and the Office of Insurance Regulation state that the bill will not have a fiscal impact on their respective agencies.

VI. Technical Deficiencies:

The bill attempts to require employer health plans to provide reimbursement for telemedicine services. Federal law pre-empts state regulation of Employer Retirement Income Security Act employer health insurance plans.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (9) is added to section 624.402, Florida Statutes, to read:

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

(9) A life or health insurer domiciled outside the United States covering only persons who, at the time of issuance or

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renewal, are nonresidents of the United States but residing legally in the United States if:

(a) The insurer does not solicit business from residents of the United States;

(b) The insurer registers with the office via a letter of notification upon commencing business from this state;

(c) Annually, by March 1, the insurer provides the following information to the office:

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

2. The type of products offered by the insurer;

3. A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered in that domicile; and

4. A copy of the filings required by the insurer's domicile;

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

(e) The insurer ceases to do business from this state and provides written notification to the office within 30 days after

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cessation.

For purposes of this subsection, the term "nonresident" means a person who has not had his or her principal place of domicile in the United States for 180 days during the 365 days before purchasing or renewing the policy; registered to vote in any state; made a statement of domicile in any state; or filed for homestead tax exemption on property in any state.

Section 2. Section 628.901, Florida Statutes, is amended to read:

628.901 Definitions ~~"Captive insurer" defined.~~—As used in ~~For the purposes of~~ this part, the term: ~~except as provided in s. 628.903, a "captive insurer" is a domestic insurer established under part I to insure the risks of a specific corporation or group of corporations under common ownership owned by the corporation or corporations from which it accepts risk under a contract of insurance.~~

(1) "Association" means a legal association of nursing homes, hospitals, skilled nursing facilities, assisted living facilities, or continuing care retirement communities.

(2) "Association captive insurer" means a company that insures risks of the member organizations of the association and their affiliated companies.

(3) "Captive insurer" means a pure captive insurer or an association captive insurer domiciled in this state and formed or licensed under this part.

(4) "Industrial insured" means an insured that:

(a) Has gross assets in excess of $50 million;

(b) Procures insurance through the use of a full-time

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employee of the insured who acts as an insurance manager or buyer or through the services of a person licensed as a property and casualty insurance agent, broker, or consultant in such person's state of domicile;

(c) Has at least 100 full-time employees; and

(d) Pays annual premiums of at least $200,000 for each line of insurance purchased from the industrial insured captive insurer, or at least $75,000 for any line of coverage in excess of at least $25 million in the annual aggregate. The purchase of umbrella or general liability coverage in excess of $25 million in the annual aggregate is deemed to be the purchase of a single line of insurance.

(5) "Industrial insured captive insurer" is a captive insurer that:

(a) Has as its stockholders or members only industrial insureds that the captive insurer insures, or has as its sole stockholder a corporation whose sole stockholders are industrial insureds that the captive insurer insures; and

1. Provides insurance only to the industrial insureds that are its stockholders or members, and affiliates thereof, or to the stockholders, and affiliates thereof, of its parent corporation; or

2. Provides reinsurance only on risks written by insurers of industrial insureds who are the stockholders or members, and affiliates thereof, of the captive insurer, or the stockholders, and affiliates thereof, of the parent corporation of the captive insurer;

(b) Maintains unimpaired capital and surplus of at least $20 million; and

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(c) If licensed in this state before December 31, 1999, or if any subsidiary formed by the licensed insurer on or after December 31, 1999, has:

1. Gross assets in excess of $10 million and procures insurance through the use of a full-time employee of the insured who acts as an insurance manager or buyer or through the services of a person licensed as a property and casualty insurance agent, broker, or consultant in such person's state of domicile;

2. At least 25 full-time employees; and

3. Annual aggregate premiums for all insurance risks which total at least $100,000.

As used in this subsection, the term "affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with one or more of the stockholders or members of an industrial insured captive insurer or one or more of the stockholders of the parent corporation of an industrial insured captive insurer.

(6) "Pure captive insurer" means a company that insures the risks of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.

Section 3. Section 628.903, Florida Statutes, is repealed.

Section 4. Section 628.905, Florida Statutes, is amended to read:

628.905 Licensing; authority.—In order to conduct insurance business in this state, a captive insurer must obtain a license from the office.

(1) A ~~Any~~ captive insurer, if ~~when~~ permitted by its charter

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or articles of incorporation, may apply to the office for a license to provide commercial property, commercial casualty, and commercial marine insurance. ~~coverage other than workers' compensation and employer's liability insurance coverage, except that~~ An industrial insured captive insurer may also apply for a license to provide workers' compensation and employer's liability insurance as set forth in subsection (5) ~~(6)~~.

(2) A ~~No~~ captive insurer, other than an industrial insured captive insurer, may not ~~shall~~ insure or accept reinsurance on any risks other than those of its parent and affiliated companies.

(3) In addition to information otherwise required by this code, each applicant captive insurer shall file with the office evidence:

(a) Of the adequacy of the loss prevention program of its insureds.

(b) That it intends to employ or contract with a reputable person or firm that possesses the appropriate expertise, experience, and character to manage the association captive insurer.

(4) If an association captive insurer operates with separate cells or segregated accounts, a certificate of insurance used to satisfy financial responsibility laws shall be issued in an amount not exceeding the total funds in the segregated accounts or separate cells of each member organization of the association.

(5) ~~(4)~~ An industrial insured captive insurer:

(a) Need not be incorporated in this state if it has been validly incorporated under the laws of another jurisdiction; ~~.~~

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(b) ~~(5) An industrial insured captive insurer~~ Is subject to all provisions of this part except as otherwise indicated; and~~.~~

(c) ~~(6) An industrial insured captive insurer~~ May not provide workers' compensation and employer's liability insurance except in excess of at least $25 million in the annual aggregate.

Section 5. Section 628.908, Florida Statutes, is created to read:

628.908 Principal place of business; annual meeting.—In order to conduct insurance business in this state, a licensed captive insurer must:

(1) Maintain its principal place of business in this state; and

(2) Annually hold in this state at least one board of directors' meeting; or, in the case of a reciprocal insurer, one subscriber's advisory committee meeting; or, in the case of a limited liability company, one managing board's meeting.

Section 6. Paragraph (a) of subsection (2) and paragraph (a) of subsection (3) of section 628.909, Florida Statutes, are amended to read:

628.909 Applicability of other laws.—

(2) The following provisions of the Florida Insurance Code shall apply to captive insurers who are not industrial insured captive insurers to the extent that such provisions are not inconsistent with this part:

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.425, and 624.426.

(3) The following provisions of the Florida Insurance Code shall apply to industrial insured captive insurers to the extent

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that such provisions are not inconsistent with this part:

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.425, 624.426, and 624.609(1).

Section 7. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to captive insurers; amending s. 624.402, F.S.; exempting certain life or health insurers covering nonresidents from having to obtain a certificate of authority; amending s. 628.901, F.S.; providing definitions; repealing s. 628.903, F.S., relating to the definition of the term "industrial insured captive insurer"; amending s. 628.905, F.S.; requiring a captive insurer to obtain a license and to file evidence that a person or firm with whom it intends to conduct business is reputable; providing that a certificate of insurance for an association captive insurer does not exceed the total funds of the association members; creating s. 628.908, F.S.; requiring a licensed captive insurer to maintain its principal place of business in this state and hold an annual meeting in this state; amending s. 628.909, F.S.; applying additional provisions of the insurance code to captive insurers; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1836
INTRODUCER:	Senator Diaz de la Portilla
SUBJECT:	Captive Insurance
DATE:	April 2, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Burgess	BI	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

Under current law captive insurance is regulated by the Office of Insurance Regulation (OIR) under part V of ch. 628, F.S., which defines a "captive insurer" as a domestic insurer that is owned by, or is under common ownership with, a specific corporation or group of corporations for which the captive insurer provides insurance coverage.[1] Every captive insurer must maintain unimpaired paid-in capital of at least $500,000 and unimpaired surplus of at least $250,000.[2] Current law also specifically defines "industrial insureds" and "industrial insured captive insurer."[3] An industrial insured captive insurer is a captive insurer that is owned by, and provides insurance coverage for, only industrial insureds. An industrial insured must have gross assets in excess of $50 million, at least 100 full-time employees, and pay annual premiums of at least $200,000 for each line of insurance. The industrial insured captive insurer must maintain unimpaired capital and surplus of at least $20 million.

Other than the requirements for captive insurers and industrial insured captive insurers, current law does not delineate any other type of captive insurance.

The bill redefines "captive insurer" and "industrial insured captive insurer," and creates and defines seven new captive insurers under ch. 628, F.S.:

- Alien captive insurer
- Association captive insurer

[1] Section 628.901, F.S.
[2] Section 628.907, F.S.
[3] Section 628.903, F.S.

- Branch captive insurer
- Captive reinsurance company
- Pure captive insurer
- Special purpose captive insurer
- Sponsored captive insurer

The bill establishes capital and reserve requirements for each captive insurer and removes the current requirement,[4] that captive insurers are also subject to the same level of capital[5] and reserves,[6] that are specified for various lines of insurance written in this state.

This bill substantially amends the following sections of the Florida Statutes:
628.901, 628.905, 628.907, 628.909, 628.911, and 628.913.

This bill creates the following sections of the Florida Statutes:
628.908, 628.910, 628.912, 628.914, 628.9141, 628.9142, 628.9143, 628.918, 628.919, 628.920, 628.921, 628.922, 628.923, and 628.924.

II. Present Situation:

Captive Insurance
A captive insurer is an insurance company primarily or exclusively insures a business entity, or entities, that owns or is an affiliate of the captive insurer. The insured business entities pay premiums to the captive insurer for specified insurance coverages. A captive insurance arrangement can provide a number of benefits, depending on the type of business arrangement, the domicile of the insured business and the captive insurer, and the coverages involved. Some benefits of captive insurance may include:

- Lower insurance cost. Two elements that an arm's length insurer must recover are acquisition cost (often in the form of agent commissions and advertising) and profit. A captive insurer would not need to factor these elements into the premium it charges.
- Potential tax savings. The premium paid by the insured entity is a deductible expense for Federal income tax purposes, and, under some circumstances, a portion of the captive insurer's income from the collected premium may not be recognized as taxable. Further, a captive insurer may be domiciled in a country where its investment income may receive more favorable tax treatment than in the United States.
- More tailored insurance plan. A captive insurer may be able to create overall savings through coverage and policy provisions that are unique to the individual business being insured.
- Cohesion of interest. Because the control of the insured and the insurer would reside in a single entity, there could be a reduction in some of the areas of potential disagreement over claim verification, investigation and valuation.

In Florida, captive insurance is regulated by the Office of Insurance Regulation (OIR) under Part V of ch. 628, F.S. That part defines a captive insurer to be "a domestic insurer established under

[4] *See* s. 628.909(2)(a), F.S.
[5] Sections 624.407, F.S.
[6] Sections 624,408, F.S.

part I[7] to insure the risks of a specific corporation or group of corporations under common ownership owned by the corporation or corporations from which it accepts risk under a contract of insurance."[8] Section 628.903(2), F.S., defines an "industrial insured captive insurer" as a captive insurer that:

- Has as its stockholders or members only industrial insureds[9] that are insured by the captive.
- Provides insurance only to the industrial insureds that are its stockholders or members and affiliates of its parent cooperation.
- Provides reinsurance to insurers only on risks written by such insurers for the industrial insureds who are stockholders or members and affiliates of the industrial insured captive or its parent company.
- Maintains unimpaired capital and surplus of at least $20 million.

Section 628.907, F.S., requires all captives to maintain unimpaired paid-in capital of at least $500,000 and unimpaired surplus of at least $250,000. Section 628.909, F.S., further requires that all captive insurers are also subject to the same level of capital[10] and reserves,[11] that are specified for various lines of insurance written in this state.

III. Effect of Proposed Changes:

Section 1 – Amends s. 628.901, F.S., to delete the current definition of captive insurer and replace it with a definition that a captive insurance company means a pure captive insurance company, association captive insurance company, captive reinsurance company, sponsored captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company. The bill further defines the following:

- Affiliated company means a company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.
- Alien captive insurance company means an insurance company formed to write insurance for its parent and affiliates and licensed under the laws of an alien jurisdiction.
- Association means a legal association of individuals, corporations, limited liability companies, partnerships, political subdivisions, or an association that has been in continuous existence for at least 1 year.
- Association captive insurance company means a company that insures risks of the member organizations of the association and their affiliated companies.
- Branch business means any insurance business transacted by a branch captive insurance company in this state.

[7] Part I of ch. 628, F.S., is entitled "STOCK AND MUTUAL INSURERS: ORGANIZATION AND CORPORATE PROCEDURES."
[8] Section 628.901, F.S.
[9] Section 628.903(1), F.S. An industrial insured must have gross assets in excess of $50 million, at least 100 full-time employees, and pay annual premiums of at least $200,000 for each line of insurance.
[10] Sections 624.407, F.S.
[11] Sections 624,408, F.S.

- Branch captive means an alien captive insurance company licensed by the commissioner to transact business of insurance in this state through a business unit with a principal place of business in this state.
- Branch operations mean any business operations of a branch captive insurance in this state.
- Captive reinsurance company means a reinsurance company that is formed or licensed under this chapter and is wholly owned by a qualifying reinsurance parent company.
- Industrial insured captive insurance company means a company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.
- Industrial insured group means a group that is a group of industrial insureds that collectively own, or control all of the voting securities of an industrial insured captive insurance company or a group created under the Liability Risk Retention Act of 1986, 15 U.S.C. s. 3901, et seq.
- Participant means an entity or affiliate of that entity, that is insured by a sponsored captive insurance company, where the losses of the participant are limited to the assets of a protected cell.
- Protected cell means a separate account established and maintained by a sponsored captive insurance company for one participant.
- Pure captive insurance company means a company that insures risks of its parent, affiliated companies, controlled unaffiliated business, or a combination thereof.
- Qualifying reinsurer parent company means a reinsurer authorized to write reinsurance by this state and that has a consolidated GAAP net worth of not less than $500 million and a consolidated debt to total capital ratio of not greater than 0.50.
- Special purpose captive insurance company means a captive insurance company that does not meet the definition of any other type of captive insurance company.
- Sponsor means an entity that is approved by the OIR to provide capital and surplus and to organize and operate a sponsored captive insurance company.
- Sponsored captive insurance company means a captive insurance company in which the minimum capital and surplus is provided by one or more sponsors, that insures the risks of separate participants, and that segregates each participant's liability through one or more protected cells.

Section 2 –Amends s. 628.905, F.S., to require captives to apply for their license through the commissioner of insurance at the OIR. The bill allows captives to do any and all insurance authorized by the insurance code except workers compensation. This provision will allow captives to write additional lines currently not allowed in ch. 628, F.S., such as employer's liability insurance.

The bill specifies restrictions for the various captives: \

- A pure captive insurance may not insure any risks other than those of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.
- An association captive insurance company may not insure any risks other than those of the member organizations of its association and their affiliated companies.
- An industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies.

- A special purpose captive insurance company may only insure the risks of its parent. Notwithstanding any other provisions of this chapter, a special purpose captive insurance company may provide insurance or reinsurance, or both, for risks as approved by the commissioner".
- A captive insurance company may not provide personal motor vehicle or homeowners' insurance coverage or any component of such coverage.
- A captive insurance company may not accept or cede reinsurance except an industrial insured captive which may insure or accept reinsurance on any risks other than those of its parent and affiliated companies.

The bill requires before receiving a license, a captive insurance company formed as a corporation or a nonprofit corporation must file with the commissioner a copy of its articles of incorporation and bylaws or if a limited liability company, a copy of its articles of organization and operating agreement. Also file with the commissioner a statement under oath by its managers showing its financial condition, and any other statements or documents required by the commissioner.

The bill requires when formed as a reciprocal the company must file with the commissioner a certified copy of the power of attorney of its attorney-in-fact, a certified copy of its subscribers' agreement, a statement under oath of its attorney-in-fact showing its financial condition. Submit to the commissioner for approval a description of the coverages, deductibles, coverage limits, and rates and any other information the commissioner may reasonable require.

The bill requires when applying for approval a captive insurance company must additionally file with the commissioner evidence of:

- The amount and liquidity of the proposed captive insurance company's assets relative to the risks to be assumed.
- The adequacy of the expertise, experience, and character of the person or persons who will manage the company.
- The overall soundness of the company's plan of operation.
- The adequacy of the loss prevention programs of the company's parent, member organizations, or industrial insureds.
- Any other factors considered relevant by the commissioner in ascertaining whether the company will be able to meet its policy obligations.

The bill requires when applying for approval a sponsored captive insurance company must file with the commissioner:

- A business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the commissioner and how the applicant will report the experience to the commissioner.
- A statement acknowledging that all financial records of sponsored captive insurance company must be made available for inspection or examination by the commissioner.
- All contracts or sample contracts between the sponsored captive insurance company and any participants.
- Evidence that expenses will be allocated to each protected cell in an equitable manner.

The bill requires a captive insurance company must pay to the office a nonrefundable fee of $200 for processing its application of license.

The bill requires a captive insurance company must pay a license fee of $300 for 1 year of registration and an annual renewal fee of $200.

The bill allows the office to charge a fee of $15 for any document requiring certification of authenticity or the signature of the commissioner or his or her designee.

Upon approval of the commissioner or his designee, a foreign or alien captive insurance company may become a domestic captive insurance by complying with the requirements and licensing of a domestic captive insurance company along with a certificate of good standing issued by the commissioner.

Section 3 –Amends s. 628.907, F.S., establishing the following amounts of unimpaired paid-in capital:

- Pure captive not less than $500,000.
- Association captive not less than $400,000.
- Industrial insured captive not less than $200,000.
- Sponsored captive not less than $500,000. However, if the sponsored captive insurance company does not assume any risk, the risks insured by the protected cells are homogeneous, and there are no more than 10 cells, the commissioner may reduce this amount to an amount not less than $150,000.
- Purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.

The bill states the commissioner may not issue a license to a captive insurance company incorporated as a nonprofit corporation unless the company possesses and maintains unrestricted net assets:

- In the case of a pure captive insurance company, not less than $250,000.
- In the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.
- In the case of a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, the commissioner must require that a trust fund, funded by an irrevocable letter of credit of credit or other acceptable asset, be established and maintained in the United States for the benefit of United States policyholders and United States ceding insurers.

The bill states captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus in excess of the limitations set forth in this chapter without the prior approval of the commissioner.

Section 4 – Creates s. 628.908, F.S. is relating to surplus requirements and restrictions on payment of dividends. The bill states the commissioner may issue a license expressly conditioned upon the captive insurance company providing to the commissioner satisfactory evidence of possession of the minimum required unimpaired surplus. Until this evidence is provided, the captive insurance company may not issue any policy, assume any liability, or otherwise provide coverage.

The bill states the commissioner may not issue a license to a captive insurance company unless the company possesses and maintains unimpaired surplus of:

- In the case of a pure captive insurance company, not less than $150,000.
- In the case of an association captive insurance company incorporated as a stock insurer or organized as a limited liability company, not less than $350,000.
- In the case of an industrial insured captive insurance company incorporated as a stock insurer or organized as a limited liability company, not less than $300,000.
- In the case of an association captive insurance company incorporated as a mutual insurer, not less than $750,000.
- In the case of an industrial insured captive insurance company incorporated as a mutual insurer, not less than $500,000.
- In the case of a sponsored captive insurance company, not less than $500,000; however, if the sponsored captive insurance company does not assume any risk, the risks insured by the protected cells are homogeneous, and there are no more than 10 cells, the commissioner may reduce this amount to an amount not less than $150,000.
- In the case of a special purpose captive insurance company, an amount determined by the commissioner; after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured;
- For a sponsored captive insurance company that does not assume any risk, the surplus may also be in the form of other high-quality securities, as approved the commissioner. Except for a sponsored captive insurance company that does assume any risk, the surplus must be in the form of cash, cash equivalent, or an irrevocable letter of credit issued by a bank charted in this state or a member bank of the Federal Reserve System with branch offices in this state and approved by the commissioner.
- A captive insurance company organized as a reciprocal insurer under this section may not be issued a license unless it possesses and thereafter maintains unimpaired surplus of $1 million.

The bill allows the commissioner to revoke the conditional license without recourse by the company if satisfactory evidence of the required capital is not provided within a maximum period of time, not to exceed 1 year, to be established by the commissioner at the time the conditional license is issued.

The bill states a captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus in excess of the limitations set forth in this chapter without the prior approval of the commissioner.

Approval of an ongoing plan for the payment of dividends or other distribution must be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the commissioner.

Section 5 – Amends s. 628.909, F.S., relating to the applicability of other statutory provisions to captive insurers. Among other changes, the bill exempts captives from the requirements of s. 624.407, F.S., and s. 624.408, F.S., which, under current law require that that captives maintain the same level of capital and reserves that are specified for various lines of insurance in this state.

Section 6 – Creates s. 628.910, F.S., relating to incorporation options and requirements. The bill provides that a pure captive insurance company or a sponsored captive insurance company may be:

- Incorporated as a stock insurer with its capital divided into shares and held by the stockholders;
- Incorporated as a public benefit, mutual benefit, or religious nonprofit corporation with members in accordance with the Florida Not For Profit Corporation Act.;
- Organized as a limited liability company with its capital divided into capital accounts and held by its members.

The bill provides that an association captive insurance company or an industrial insured captive insurance company may be:

- Incorporated as a stock insurer with its capital divided into shares and held by the stockholders;
- Organized as a limited liability company with its capital divided into capital accounts and held by its members;
- Incorporated as a mutual insurer without capital stock, the governing body of which is elected by the member organizations of its association; or
- Organized as a reciprocal insurer in accordance with chapter 629;

The bill provides that a captive insurance company may not have fewer than three incorporations or organizers of whom not fewer than two must be residents of this state.

The bill provides that in the case of a captive insurance company formed as a corporation, a nonprofit corporation, or a limited liability company, before the articles of incorporation or organization are transmitted to the Secretary of State, the incorporators must petition the commissioner to issue a certificate setting forth a finding that the establishment and maintenance of the proposed entity will promote the general good of the state. The commissioner must consider:

a) The character, reputation, financial standing, and purposes of the incorporators or organizers;
b) The character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors or managers; and

c) Other aspects as the commissioner considers advisable.

In the case of a captive insurance company formed as a reciprocal insurer, the bill requires that the organizers must petition the commissioner to issue a certificate with the finding that the establishment and maintenance of the proposed association will promote the general good of the state.

In the case of a captive insurance company licensed as a branch captive insurance company, the bill requires that the alien captive insurance company must petition the commissioner to issue a certificate finding that, after considering the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors or managers of the alien companies, the establishment and maintenance of the proposed association will promote the general good of the state.

In the case of a captive insurance company formed as a corporation or a nonprofit corporation, at least one of the members of the board of directors of a captive insurance company incorporated in this state must be a resident of this state.

In the case of a captive insurance company formed as a limited liability company, at least one of the managers of the captive insurance company must be a resident of this state.

In the case of a captive insurance company formed as a reciprocal insurer, at least one of the members of the subscribers' advisory committee must be a resident of this state.

Section 7 – Amends s. 628.911, F.S., relating to reports and statements. The bill requires captive insurance companies and captive reinsurance companies to submit an annual report on financial condition to the commissioner before March 1st. The report must be verified by oath from two executive officers and the report must be compiled using generally accepted accounting principles unless the commissioner approves alternative accounting measures. The Financial Services Commission may adopt by rule any additional accounting requirements.

The bill allows a pure captive insurer may make written application for filing the required report on a fiscal year-end that is consistent with the parent company's fiscal year-end. If an alternative reporting date is granted the report is due 60 days after the parent company's fiscal year end. Additionally, for verification of premium tax return a pure captive must file before March 1st of each year pages 1-7 of the NAIC Annual Statement verified by oath of two of its executive officers.

The bill also states 60 days after the fiscal year end, a branch captive insurance company must file with the commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of its executive officers. If the commissioner is satisfied that the annual report filed by the alien captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the captive annual statement for business written in the alien jurisdiction. Such waiver must be in writing and subject to public inspection.

Section 8 – Creates s. 628.912, F.S, relating to discounting of loss and loss adjustment expense reserves. The bill allows a sponsored captive insurance company and a captive reinsurance company may discount its loss and loss adjustment expense reserves at treasury rates applied to the applicable payments projected through the use of the expected payment pattern associated with reserves. Additionally, a sponsored captive insurance company and a captive reinsurance company must file annually an actuarial opinion on the loss and loss adjustment expense reserves provided by an actuarial opinion on loss and loss adjustment expense reserves provided by an independent actuary. The actuary may not be an employee of the captive company or its affiliates.

The bill allows the commissioner may disallow the discounting of reserves if a sponsored captive insurance company or a captive reinsurance company violates a provision of this part.

Section 9 – Amends s. 628.913, F.S., relating to captive reinsurance companies. The bill states a captive reinsurance company, if permitted by its articles of incorporation or charter, may apply to the commissioner for a license to write reinsurance covering property and casualty insurance or reinsurance contracts. A captive reinsurance company authorized by the commissioner may write reinsurance contracts covering risks in any state.

The bill requires that to conduct business in this state, a captive reinsurance company must:

- Obtain from the commissioner a license authorizing it to conduct business as a captive reinsurance company in this state.
- Hold at least one board of directors' meeting each year in this state.
- Maintain its principal place of business in this state.
- Appoint a registered agent to accept service of process and act otherwise on its behalf in this state.

Additionally, before receiving a license, a captive reinsurance company must file with the commissioner:

- A certified copy of its charter and bylaws.
- A statement under oath of its president and secretary showing its financial condition.
- Other documents required by the commissioner.

The bill states, in addition to the information required by this section, the captive reinsurance company must file with the commissioner evidence of:

- The amount of liquidity of the captive reinsurance company's assets relative to the risks to be assumed.
- The adequacy of the expertise, experience, and character of the person who manages the company.
- The overall soundness of the company's plan of operation.
- Other overall factors considered relevant by the commissioner in ascertaining if the company would be able to meet its policy obligations.

Section 10 – Creates s. 628.914, F.S., relating to minimum capitalization and reserves for captive reinsurance companies. The bill states the commissioner may not issue a license to a captive reinsurance company unless the company possesses and maintains capital or unimpaired surplus of not less than the greater of $300 million or 10% of reserves. The surplus may be in the form of cash or securities. The commissioner may prescribe additional capital or surplus based upon the type, volume, and nature of the insurance business transacted. Further, a captive reinsurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus in excess of the limitations without the prior approval of the commissioner.

Section 11 – Creates s. 628.9141, F.S., relating to incorporation of a captive reinsurance company. The bill requires a captive reinsurance company must be incorporated as a stock insurer with its capital divided into shares and held by its shareholders. A captive reinsurance company may not have fewer than three incorporators of whom at least must be residents of this state. Before the articles of incorporation are transmitted to the Secretary of State, the incorporators shall petition the commissioner to issue a certificate finding that the establishment and maintenance of the proposed corporation promotes the general good of this state.

The bill states before the articles of incorporation are transmitted to the Secretary of State, the incorporators shall petition the commissioner to issue a certificate finding that the establishment and maintenance of the proposed corporation promotes the general good of this state. In arriving at this finding, the commissioner must consider:

- The character, reputation, financial standing, and purposes of the incorporators.
- The character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors.
- Other factors the commissioner considers advisable.
- The capital stock of a captive reinsurance company must be issued at par value or greater.
- At least one of the members of the board of directors of a captive reinsurance company incorporated in this state must be a resident of this state.

Section 12 – Creates s. 628.9142, F.S., relating to provisions on the effect of reinsurance on required reserves. The bill allows a captive insurance company may provide reinsurance, as authorized in this part, on risks ceded by any other insurer. Additionally a captive insurance company may take credit for reserves on risks or portions of risks ceded to authorized insurers or reinsurers and unauthorized insurers or reinsurers complying with the provisions of s. 624.610, F.S. The bill restricts a captive insurer from taking credit for reserves on risks or portions of risks ceded to an unauthorized insurer or reinsurer if the insurer or reinsurer is not in compliance with s. 624.610, F.S.

Section 13 – Creates s. 628.9143, F.S., relating to annual captive reinsurance tax. The bill requires a captive reinsurance company must pay to the office by March 1 of each year a captive reinsurance tax of $5,000. The tax provided in this section is the only tax collectible under the laws of this state from a captive reinsurance company, and no tax on reinsurance premiums, other than occupation tax, nor any other taxes, except ad valorem taxes on real and personal property used in the production of income, may be levied or collected from a captive reinsurance company by the state or a county, city, or municipality within this state. The bill allows a captive

reinsurance company to be subject to sanctions for failing to make returns or to pay all taxes required by this section.

Section 14 – Creates s. 628.3918, F.S., relating to management of assets of a captive reinsurance company. The bill requires at least 35 percent of the assets of a captive reinsurance company must be managed by an asset manager domiciled in this state.

Section 15 – Creates s. 628.919, F.S., establishing regulations and standards to ensure risk management control by a parent company. The bill states the Financial Services Commission shall adopt rules establishing standards to ensure that a parent company or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the pure captive insurance company.

Section 16 – Creates s. 628.920, F.S., relating to the conversion of certain stock, mutual corporations or limited liability companies into reciprocal insurers. The bill states an association captive insurance company or industrial insured group formed as a stock or mutual corporation or a limited liability company may be converted to or merged with and into a reciprocal insurer in accordance with a plan and the provisions of this section.

The bill requires that a plan for conversion or merger must be fair and equitable to the:

- Shareholders in the case of a stock insurer.
- Members in the case of a limited liability company.
- Policyholders in the case of a mutual insurer.

Additionally the bill requires the plan must provide for the purchase of the shares of any nonconsenting shareholder of a stock insurer, of the member interest of any nonconsenting member of a limited liability company, of the policyholder interest of any nonconsenting policyholder of a mutual insurer in substantially the same manner and subject to the same rights and conditions as are accorded a dissenting shareholder, dissenting member, or a dissenting policyholder pursuant to the provisions of this chapter, provided the merger of a limited liability company requires the consent of all members unless waived in an operating agreement signed by all of the members of the limited liability company.

The bill states in the case of a conversion authorized under this section, the conversion must be accomplished under a reasonable plan and procedure as may be approved by the commissioner; however, the commissioner may not approve the plan of conversion unless the plan:

- Satisfies the provisions of this section.
- Provides for a hearing, of which notice has been given to the insurer, its directors, officers, and stockholders, members and managers in the case of a limited liability company.; or policyholders, in the case of a mutual insurer, all of whom have the right to appear at the hearing, except that the director may waive or modify the requirements for the hearing. However, if a notice of hearing is required, but no hearing is requested, the commissioner may cancel the hearing.

- Provides for the conversion of existing stockholder, member, or policyholder interests into subscriber interests in the resulting reciprocal insurer, proportionate to stockholder, member, or policyholder interests in the stock or mutual insurer or limited liability company.

The bill states how a conversion plan is approved:

- In the case of a stock insurer or limited liability company, by a majority of the shares or interests entitled to vote represented in person or by proxy at a duly called regular or special meeting at which a quorum is present.
- In the case of a mutual insurer, by a majority of the voting interests of policyholders represented in person or by proxy at a duly called regular or special meeting at which a quorum is present.

The bill states the commissioner shall approve the plan of conversion if the commissioner finds that the conversion will promote the general good of the state in conformity with those standards provided in this part. If the commissioner approves the plan, the commissioner must amend the converting insurer's certificate of authority to reflect conversion to a reciprocal insurer and issue the amended certificate of authority to the company's attorney-in-fact.

The bill states upon issuance of an amended certificate of authority of a reciprocal insurer by the commissioner, the conversion is effective. Upon the effectiveness of the conversion, the corporate existence of the converting insurer must cease and the resulting reciprocal insurer must notify the Secretary of State of the conversion.

The bill states a merger authorized pursuant to the provisions of this section must be accomplished substantially in accordance with the procedures provided in this part, except that, only for purposes of the merger:

- The plan or merger must satisfy the requirements The plan must be fair and equitable to the:
    - Shareholders in the case of a stock insurer.
    - Members in the case of a limited liability company.
    - Policyholders in the case of a mutual insurer.

- The subscribers' advisory committee of a reciprocal insurer must be equivalent to the board of directors of a stock or mutual insurance company or the managers of a limited liability company.
- The subscribers of a reciprocal insurer must be the equivalent of the policyholders of a mutual insurance company.
- If a subscribers' advisory committee does not have a president or secretary, the officers of the committee having substantially equivalent duties are considered the president and secretary of the committee.
- The commissioner must approve the articles of merger if the commissioner finds that the merger will promote the general good of the state in conformity with those standards provided in this part. If the commissioner approves the articles of merger, the commissioner must endorse his or her approval on the articles and the surviving insurer must present the endorsement of the commissioner to the Secretary of State at the Secretary of State's office.

- Notwithstanding the provisions of this part, the commissioner may permit the formation, without surplus, of a captive insurance company organized as a reciprocal insurer, into which an existing captive insurance company may be merged for the purpose of facilitating a transaction provided for in this section. However, there may be no more than one authorized insurance company surviving the merger.
- An alien insurer may be a party to a merger if the requirements for the merger between a domestic and a foreign insurer pursuant to the provisions of this chapter apply to a merger between a domestic and an alien insurer provided by this subsection. The alien insurer must be treated as a foreign insurer pursuant to the provisions of this chapter and other jurisdictions must be the equivalent of a state.

Section 17 – Creates s. 628.921, F.S., relating to the formation of a sponsored captive insurance company and the establishment of protected cells. The bill allows one or more sponsors may form a sponsored captive insurance company under this part.

A sponsored captive insurance company formed or licensed under this part may establish and maintain one or more protected cells to insure risks of one or more participants, subject to the following conditions:

- The shareholders of a sponsored captive insurance company must be limited to its participants and sponsors.
- Each protected cell must be accounted for separately on the books and records of the sponsored captive insurance company to reflect he financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions to participants.
- The assets of the protected cell must not be chargeable with liabilities arising out of any other insurance business the sponsored captive insurance company may conduct.
- Sale, exchange, or other transfer of assets may not be made by the sponsored captive insurance company between or among any of its protected cells without the consent of the protected cells.
- A sponsored captive insurance company must annually file with the commissioner financial reports the commissioner requires, which must include, but are not limited to, accounting statements detailing the financial experience of each protected cell.
- A sponsored captive insurance company must notify the commissioner in writing within business days after a protected cell becomes insolvent or otherwise unable to meet its claim or expense obligations.
- A participant contract may not take effect without the commissioner's prior written approval, and the addition of each new protected cell and withdrawal of any participant of any existing protected cell constitutes a change in the business plan, which requires the commissioner's prior written approval.

Section 18 – Creates s. 628.922, F.S., which provides that a sponsor of a sponsored captive insurance company must be:

- an insurer licensed pursuant to the laws of a state;
- an insurance holding company that controls an insurer licensed under the laws of any state;

- a reinsurer authorized or approved under the laws of a state; or
- a captive insurance company formed or licensed in Florida.

The bill provides that a risk retention group may not be a sponsor or a participant of a sponsored captive insurance company. The bill provides that the business written by a sponsored captive insurance company with respect to each protected cell must be:

- Fronted by an insurance company licensed under the laws of any state or any jurisdiction if the insurance company is a wholly owned subsidiary of an insurance company licensed under the laws of any state;
- Reinsured by a reinsurer authorized or approved by this state; or
- Secured by a trust fund in the United States for the benefit of policyholders and claimants funded by an irrevocable letter of credit or other asset acceptable to the OIR. Under this option, the amount of security provided by the trust fund may not be less than the reserves associated with those liabilities.

Section 19 –Creates s, 628.923, F.S., which allows an association, a corporation, a limited liability company, a partnership, a trust, or another business entity to be a participant in a sponsored captive insurance company. The bill provides that a sponsor may be a participant in a sponsored captive insurance company. The bill provides that a participant need not be a shareholder or an affiliate of the sponsored captive insurance company. The bill provides that a participant may insure only its own risks through a sponsored captive insurance company, unless otherwise approved by the OIR.

Section 20 – creates s. 628.924, F.S., which provides that a licensed captive insurance company that meets the necessary requirements of the bill is authorized to act as an insurer in Florida.

Section 21 – provides an effective date of July 1, 2011.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill substantially changes the capital and surplus requirements for captive insurers. This may have an impact on the level of assurance that captive insurers are able to meet their claims obligations.

C. Government Sector Impact:

Current law requires captive insurers to submit annual reports. The bill mandates elements that must be included in the annual report, and authorizes the Financial Services Commission to engage in rulemaking to adopt the form required for the annual report.

The bill requires the Financial Services Commission to engage in rulemaking to establish the standards necessary to ensure that a parent company is able to exercise control of the risk management function of a controlled unaffiliated business insured by a pure captive insurance company.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 203 - 1533

and insert:

Section 3. Present subsections (10), (11), and (12) of section 817.234, Florida Statutes, are renumbered as subsections (11), (12), and (13), respectively, and a new subsection (10) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle

243424

insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

And the title is amended as follows:

Delete lines 12 - 112

and insert:

statement regarding insurance fraud; amending s. 817.234, F.S.; providing civil penalties for fraudulent insurance claims involving motor vehicle insurance; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment to Amendment (243424) (with title amendment)

Delete lines 3 - 30
and insert:
Delete everything after the enacting clause
and insert:
Section 1. Subsection (1) of section 316.066, Florida Statutes, is amended to read:
316.066 Written reports of crashes.—
(1)(a) A Florida Traffic Crash Report, Long Form, must ~~is required to~~ be completed and submitted to the department within

328022

10 days after ~~completing~~ an investigation is completed by the ~~every~~ law enforcement officer who in the regular course of duty investigates a motor vehicle crash:

1. That resulted in death, ~~or~~ personal injury, or any indication of complaints of pain or discomfort by any of the parties or passengers involved in the crash; ~~.~~

2. That involved one or more passengers, other than the drivers of the vehicles, in any of the vehicles involved in the crash;

3.~~2.~~ That involved a violation of s. 316.061(1) or s. 316.193; or~~.~~

4.~~3.~~ In which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if such action is appropriate, in the officer's discretion.

(b) In every crash for which a Florida Traffic Crash Report, Long Form, is not required by this section, the law enforcement officer may complete a short-form crash report or provide a short-form crash report to be completed by each party involved in the crash. Short-form crash reports prepared by the law enforcement officer shall be maintained by the officer's agency.

(c) The long-form and the short-form report must include:

1. The date, time, and location of the crash.

2. A description of the vehicles involved.

3. The names and addresses of the parties involved.

4. The names and addresses of all passengers in all vehicles involved in the crash, each clearly identified as being a passenger and the identification of the vehicle in which they were a passenger.

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5.~~4.~~ The names and addresses of witnesses.

6.~~5.~~ The name, badge number, and law enforcement agency of the officer investigating the crash.

7.~~6.~~ The names of the insurance companies for the respective parties involved in the crash.

(d)~~(c)~~ Each party to the crash must ~~shall~~ provide the law enforcement officer with proof of insurance, which must ~~to~~ be included in the crash report. If a law enforcement officer submits a report on the accident, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

(e)~~(d)~~ The driver of a vehicle that was in any manner involved in a crash resulting in damage to any vehicle or other property in an amount of $500 or more~~,~~ which ~~crash~~ was not investigated by a law enforcement agency, shall, within 10 days after the crash, submit a written report of the crash to the department or traffic records center. The entity receiving the report may require witnesses of the crash ~~crashes~~ to render reports and may require any driver of a vehicle involved in a crash of which a written report must be made ~~as provided in this section~~ to file supplemental written reports if ~~whenever~~ the original report is deemed insufficient by the receiving entity.

(f) The investigating law enforcement officer may testify at trial or provide a signed affidavit to confirm or supplement the information included on the long-form or short-form report.

~~(e) Short-form crash reports prepared by law enforcement shall be maintained by the law enforcement officer's agency.~~

Section 2. Subsection (6) is added to section 400.991, Florida Statutes, to read:

400.991 License requirements; background screenings; prohibitions.—

(6) All forms that constitute part of the application for licensure or exemption from licensure under this part must contain the following statement:

INSURANCE FRAUD NOTICE.—Submitting a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, when seeking an exemption from licensure as a health care clinic, or when demonstrating compliance with part X of chapter 400, Florida Statutes, is a fraudulent insurance act, as defined in s. 626.989 or s. 817.234, Florida Statutes, subject to investigation by the Division of Insurance Fraud, and is grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Section 626.9894, Florida Statutes, is created to read:

626.9894 Motor vehicle insurance fraud direct-support organization.—

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

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(a) "Division" means the Division of Insurance Fraud of the Department of Financial Services.

(b) "Motor vehicle insurance fraud" means any act defined as a "fraudulent insurance act" under s. 626.989, which relates to the coverage of motor vehicle insurance as described in part XI of chapter 627.

(c) "Organization" means the direct-support organization established under this section.

(2) ORGANIZATION ESTABLISHED.—The division may establish a direct-support organization, to be known as the "Automobile Insurance Fraud Strike Force," whose sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The organization shall:

(a) Be a not-for-profit corporation incorporated under chapter 617 and approved by the Department of State.

(b) Be organized and operated to conduct programs and activities; to raise funds; to request and receive grants, gifts, and bequests of money; to acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and to make grants and expenditures to or for the direct or indirect benefit of the division, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration, and the Department of Health to the extent that such grants and expenditures are to be used exclusively to advance the purpose of prosecuting, investigating, or preventing motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel if such grants

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and expenditures do not interfere with prosecutorial independence or otherwise create conflicts of interest which threaten the success of prosecutions.

(c) Be determined by the division to operate in a manner that promotes the goals of laws relating to motor vehicle insurance fraud, that is in the best interest of the state, and that is in accordance with the adopted goals and mission of the division.

(d) Use all of its grants and expenditures solely for the purpose of preventing and decreasing motor vehicle insurance fraud, and not for the purpose of lobbying as defined in s. 11.045.

(e) Be subject to an annual financial audit in accordance with s. 215.981.

(3) CONTRACT.—The organization shall operate under written contract with the division. The contract must provide for:

(a) Approval of the articles of incorporation and bylaws of the organization by the division.

(b) Submission of an annual budget for the approval of the division. The budget must require the organization to minimize costs to the division and its members at all times by using existing personnel and property and allowing for telephonic meetings when appropriate.

(c) Certification by the division that the direct-support organization is complying with the terms of the contract and in a manner consistent with the goals and purposes of the department and in the best interest of the state. Such certification must be made annually and reported in the official minutes of a meeting of the organization.

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(d) Allocation of funds to address motor vehicle insurance fraud.

(e) Reversion of moneys and property held in trust by the organization for motor vehicle insurance fraud prosecution, investigation, and prevention to the division if the organization is no longer approved to operate for the department or if the organization ceases to exist, or to the state if the division ceases to exist.

(f) Specific criteria to be used by the organization's board of directors to evaluate the effectiveness of funding used to combat motor vehicle insurance fraud.

(g) The fiscal year of the organization, which begins July 1 of each year and ends June 30 of the following year.

(h) Disclosure of the material provisions of the contract, and distinguishing between the department and the organization to donors of gifts, contributions, or bequests, including providing such disclosure on all promotional and fundraising publications.

(4) BOARD OF DIRECTORS.—The board of directors of the organization shall consist of the following seven members:

(a) The Chief Financial Officer, or designee, who shall serve as chair.

(b) Two state attorneys, one of whom shall be appointed by the Chief Financial Officer and one of whom shall be appointed by the Attorney General.

(c) Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.

(d) Two representatives of local law enforcement agencies, both of whom shall be appointed by the Chief Financial Officer.

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The officer who appointed a member of the board may remove that member for cause. The term of office of an appointed member expires at the same time as the term of the officer who appointed him or her or at such earlier time as the person ceases to be qualified.

(5) USE OF PROPERTY.—The department may authorize, without charge, appropriate use of fixed property and facilities of the division by the organization, subject to this subsection.

(a) The department may prescribe any condition with which the organization must comply in order to use the division's property or facilities.

(b) The department may not authorize the use of the division's property or facilities if the organization does not provide equal membership and employment opportunities to all persons regardless of race, religion, sex, age, or national origin.

(c) The department shall adopt rules prescribing the procedures by which the organization is governed and any conditions with which the organization must comply to use the division's property or facilities.

(6) CONTRIBUTIONS.—Any contributions made by an insurer to the organization shall be allowed as appropriate business expenses for all regulatory purposes.

(7) DEPOSITORY.—Any moneys received by the organization may be held in a separate depository account in the name of the organization and subject to the provisions of the contract with the division.

(8) DIVISION'S RECEIPT OF PROCEEDS.—If the division

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receives proceeds from the organization, those proceeds shall be deposited into the Insurance Regulatory Trust Fund.

Section 4. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant to this section shall be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Section 627.730, Florida Statutes, is amended to read:

627.730 Florida Motor Vehicle No-Fault Law.—Sections 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the "Florida Motor Vehicle No-Fault Law."

Section 6. Section 627.731, Florida Statutes, is amended to read:

627.731 Purpose; legislative intent.—The purpose of the no-fault law ~~ss. 627.730-627.7405~~ is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles required to be registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience.

(1) The Legislature finds that automobile insurance fraud remains a major problem for state consumers and insurers. According to the National Insurance Crime Bureau, in recent years this state has been among those states that have the highest number of fraudulent and questionable claims.

(2) The Legislature intends to balance the insured's

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interest in prompt payment of valid claims for insurance benefits under the no-fault law with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. To that end, the Legislature intends that the investigation and prevention of fraudulent insurance acts in this state be enhanced, that additional sanctions for such acts be imposed, and that the no-fault law be revised to remove incentives for fraudulent insurance acts. The Legislature intends that the no-fault law be construed according to the plain language of the statutory provisions, which are designed to meet these goals.

(3) The Legislature intends that:

(a) Insurers properly investigate claims, and as such, be allowed to obtain examinations under oath and sworn statements from any claimant seeking no-fault insurance benefits, and to request mental and physical examinations of persons seeking personal injury protection coverage or benefits.

(b) Any false, misleading, or otherwise fraudulent activity associated with a claim render the entire claim invalid. An insurer must be able to raise fraud as a defense to a claim for no-fault insurance benefits irrespective of any prior adjudication of guilt or determination of fraud by the Department of Financial Services.

(c) Insurers toll the payment or denial of a claim, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act, as defined in s. 626.989, has been committed.

(d) Insurers discover the names of all passengers involved in an automobile accident before paying claims or benefits pursuant to an insurance policy governed by the no-fault law. A

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rebuttable presumption must be established that a person was not involved in the event giving rise to the claim if that person's name does not appear on the police report.

(e) The insured's interest in obtaining competent counsel must be balanced with the public's interest in preventing a no-fault system that encourages litigation by allowing for exorbitant attorney's fees. Courts should limit attorney fee awards so as to eliminate the incentive for attorneys to manufacture unnecessary litigation.

Section 7. Section 627.7311, Florida Statutes, is created to read:

627.7311 Implementation of no-fault law.—The provisions, schedules, and procedures authorized under the no-fault law shall be implemented by insurers and have full force and effect regardless of their express inclusion in an insurance policy, and an insurer is not required to amend its policy to implement such provisions, schedules, or procedures.

Section 8. Section 627.732, Florida Statutes, is reordered and amended to read:

627.732 Definitions.—As used in the no-fault law ~~ss. 627.730-627.7405~~, the term:

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-

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owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; or ~~nor does the term include~~ a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment may not ~~cannot~~ be used by patients who are not patients of the registered clinic

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~~for medical treatment of services~~. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period ~~provided in this paragraph~~ may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(9) ~~(2)~~ "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(c) Not primarily for the convenience of the patient, physician, or other health care provider.

(10) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of this state, and any trailer or semitrailer designed for use with such vehicle, and includes:

(a) A "private passenger motor vehicle," which is any motor vehicle that ~~which~~ is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type.

(b) A "commercial motor vehicle," which is any motor vehicle that ~~which~~ is not a private passenger motor vehicle.

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The term ~~"motor vehicle"~~ does not include a mobile home or any motor vehicle that ~~which~~ is used in mass transit, other than public school transportation, and designed to transport more than five passengers exclusive of the operator of the motor vehicle and that ~~which~~ is owned by a municipality, a transit authority, or a political subdivision of the state.

(11)~~(4)~~ "Named insured" means a person, usually the owner of a vehicle, identified in a policy by name as the insured under the policy.

(12) "No-fault law" means the Florida Motor Vehicle No-Fault Law codifed at ss. 627.730-627.7407.

(13)~~(5)~~ "Owner" means a person who holds the legal title to a motor vehicle; or, if ~~in the event~~ a motor vehicle is the subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.

(15)~~(6)~~ "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere.

(2)~~(7)~~ "Certify" means to swear or attest to being true or represented in writing.

(3) "Claimant" means the person, organization, or entity seeking benefits, including all assignees.

(5)~~(8)~~ "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the

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medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can respond immediately to any emergencies if needed.

(6) ~~(9)~~ "Incident," with respect to services considered as incident to a physician's professional service, for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means ~~such~~ services that are ~~must be~~ an integral, even if incidental, part of a covered physician's service.

(7) ~~(10)~~ "Knowingly" means that a person, with respect to information, has actual knowledge of the information, ~~,~~ acts in deliberate ignorance of the truth or falsity of the information, ~~,~~ or acts in reckless disregard of the information. ~~,~~ ~~and~~ Proof of specific intent to defraud is not required.

(8) ~~(11)~~ "Lawful" or "lawfully" means in substantial compliance with all relevant applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.

(4) ~~(12)~~ "Hospital" means a facility that, at the time services or treatment were rendered, was licensed under chapter 395.

(14) ~~(13)~~ "Properly completed" means providing truthful, substantially complete, and substantially accurate responses ~~as~~ to all material elements of ~~to~~ each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as agreed by the parties.

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(17)~~(14)~~ "Upcoding" means submitting ~~an action that submits~~ a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. The term does not include an otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

(16)~~(15)~~ "Unbundling" means submitting ~~an action that submits~~ a billing code that is properly billed under one billing code, but that has been separated into two or more billing codes~~,~~ and would result in payment greater than the ~~in~~ amount that ~~than~~ would be paid using one billing code.

Section 9. Subsections (1) and (4) of section 627.736, Florida Statutes, are amended, subsections (5) through (16) of that section are redesignated as subsections (6) through (17), respectively, a new subsection (5) is added to that section, present subsection (5), paragraph (b) of present subsection (6), paragraph (b) of present subsection (7), and present subsections (8), (9), and (10) of that section are amended, to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 must ~~shall~~ provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other

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persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(c),~~ to a limit of $10,000 for loss sustained by ~~any~~ such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses, charged pursuant to subsection (6), for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and for medically necessary ambulance, hospital, and nursing services. However, the medical benefits ~~shall~~ provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following ~~persons or entities~~:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under part III of chapter 401 which ~~ss. 401.2101-401.45 that~~ provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such ~~practitioner or~~ practitioners and the spouse, parent, child, or sibling of such ~~that practitioner or those~~ practitioners.

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4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under part X of chapter 400 which ~~ss. 400.990-400.995 that~~ is:

a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

6. An acupuncturist licensed under chapter 457.

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If any services under this paragraph are provided by an entity or clinic described in subparagraph 3., subparagraph 4., or subparagraph 5., the entity or clinic must provide the insurer at the initial submission of the claim with a form adopted by the Department of Financial Services which documents that the entity or clinic meets applicable criteria for such entity or clinic and includes a sworn statement or affidavit to that effect. Any change in ownership requires the filing of a new form within 10 days after the date of the change in ownership. ~~The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.~~

(b) *Disability benefits.*—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.

(c) *Death benefits.*—Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the

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deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection by~~ marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurers may not ~~insurer shall~~ require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such ~~required~~ benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An ~~Any~~ insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates ~~shall be deemed to have violated~~ part IX of chapter 626, and such violation constitutes ~~shall constitute~~ an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An~~; and any such~~ insurer committing such violation is ~~shall be~~ subject to the penalties afforded in such part, as well as those that are ~~which may be~~ afforded elsewhere in the insurance code.

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~

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upon the receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits are ~~under ss. 627.730-627.7405 shall be~~ subject to the provisions of the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by the no-fault law ~~ss. 627.730-627.7405~~.

(b) Personal injury protection insurance benefits paid pursuant to this section are ~~shall be~~ overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer.

(c) If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to

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consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must ~~shall~~ include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. An insurer's failure to send an itemized specification or explanation of benefits does not waive other grounds for rejecting an invalid claim.

(d) A ~~However, notwithstanding the fact that written notice has been furnished to the insurer, Any~~ payment is ~~shall~~ not ~~be deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to establish~~ that the insurer is not responsible for ~~the~~ payment. An insurer may obtain evidence and assert any ground for adjustment or rejection of a ~~For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the~~ claim that is ~~was~~ unrelated, ~~was~~ not medically necessary, ~~or was~~ unreasonable, or submitted ~~that the amount of the charge was in excess of that permitted under, or~~ in violation of~~,~~ subsection (6) ~~(5). Such assertion by the insurer may be made~~ at any time, including after payment of the claim, ~~or~~ after the 30-day ~~time~~ period for payment set forth in ~~this~~ paragraph (b), or after the filing of a lawsuit.

(e) The 30-day period for payment is tolled while the

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insurer investigates a fraudulent insurance act, as defined in s. 626.989, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify the claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date it has a reasonable belief that such act has been committed. The insurer must pay or deny the claim, in full or in part, within 90 days after the date the written notice of the fact of a covered loss and of the amount of the loss was provided to the insurer. However, no payment is due to a claimant that has violated paragraph (k).

(f) ~~(c)~~ Notwithstanding any local lien law, upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002~~(9)~~, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such ~~a~~ claim ~~from a physician or dentist who provided emergency services and care or who provided hospital inpatient care~~ may ~~then~~ be used by the insurer to pay other claims. The time periods specified in paragraph (b) for ~~required~~ payment of personal injury protection benefits are ~~shall be~~ tolled for the period of time that an insurer is required ~~by this paragraph~~ to hold payment of a claim that is

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not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(g) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. However, interest on a payment that is overdue pursuant to paragraph (e) shall be calculated from the date the insurer denies payment. Interest is ~~shall be~~ due at the time payment of the overdue claim is made.

(h) ~~(e)~~ The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2. if~~, provided~~ the relative at the time of the accident is domiciled in the owner's

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household and is not ~~himself or herself~~ the owner of a motor vehicle with respect to which security is required under the no-fault law ~~ss. 627.730-627.7405~~.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle if~~, provided~~ the injured person is not ~~himself or herself~~:

a. The owner of a motor vehicle with respect to which security is required under the no-fault law ~~ss. 627.730-627.7405~~; or

b. Entitled to personal injury benefits from the insurer of the owner ~~or owners~~ of such a motor vehicle.

(i) ~~(f)~~ If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable is ~~shall be~~ as specified in subsection (1), and any insurer paying the benefits is ~~shall be~~ entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(j) ~~(g)~~ It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(k) ~~(h)~~ Benefits are ~~shall~~ not ~~be~~ due or payable to a claimant who knowingly: ~~or on the behalf of an insured person if that person has~~

1. Submits a false or misleading statement, document,

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record, or bill;

2. Submits false or misleading information; or

3. Has otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989.

A claimant that violates this paragraph is not entitled to any personal injury protection benefits or payment for any bills and services, regardless of whether a portion of the claim may be legitimate. However, a claimant that does not violate this paragraph may not be denied benefits solely due to a violation by another claimant.

(l) Notwithstanding any remedies afforded by law, the insurer may recover from a claimant who violates paragraph (k) any sums previously paid to a claimant and may bring any available common law and statutory causes of action. A claimant has violated paragraph (k) ~~committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy,~~ if the fraud is admitted to in a sworn statement ~~by the insured~~ or ~~if it is~~ established in a court of competent jurisdiction. Any insurance fraud voids ~~shall void~~ all coverage arising from the claim related to ~~such fraud under the personal injury protection coverage of~~ the claimant ~~insured person~~ who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before ~~prior to~~ the discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~ recoverable by the insurer from the claimant ~~person~~ who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action

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in which it prevails in an insurer's action to enforce its right of recovery under this paragraph. This paragraph does not preclude or limit an insurer's right to deny a claim based on other evidence of fraud or affect an insurer's right to plead and prove a claim or defense of fraud under common law. If a physician, hospital, clinic, or other medical institution violates paragraph (k), the injured party is not liable for, and the physician, hospital, clinic, or other medical institution may not bill the insured for, charges that are unpaid because of failure to comply with paragraph (k). Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

(5) INSURER INVESTIGATIONS.—An insurer has the right and duty to conduct a reasonable investigation of a claim. In the course of the insurer's investigation of a claim:

(a) Any records review need not be based on a physical examination and may be obtained at any time, including after reduction or denial of the claim.

1. The records review must be conducted by a practitioner within the same licensing chapter as the medical provider whose records are being reviewed unless the records review is performed by a physician licensed under chapter 458 or chapter 459.

2. The 30-day period for payment under paragraph (4)(b) is tolled from the date the insurer sends its request for treatment records to the date that the insurer receives the treatment records.

3. The insured, claimant, or medical provider may impose a reasonable, cost-based fee that includes only the cost of

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copying and postage and not the cost of labor for copying.

(b) In all circumstances, an insured seeking benefits under the no-fault law must comply with the terms of the policy, which includes, but is not limited to, submitting to examinations under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

(c) An insurer may deny benefits if the insured, claimant, or medical provider fails to:

1. Cooperate in the insurer's investigation;

2. Commits a fraud or material misrepresentation; or

3. Comply with this subsection.

(d) The claimant may not file suit unless and until it complies with this subsection.

(6) ~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) ~~1.~~ Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only ~~a reasonable amount pursuant to this section~~ for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment~~,~~ if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such charges may not exceed the reimbursement schedule under this paragraph ~~a charge be in excess of the amount the person or institution customarily~~

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~~charges for like services or supplies~~. ~~With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.~~

1.~~2.~~ The insurer shall ~~may~~ limit reimbursement to no more than 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002~~(9)~~ provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the

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outpatient services.

f. For all other medical services, ~~supplies, and care,~~ 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For all other supplies and care, including durable medical equipment and care and services rendered by ambulatory surgical centers and clinical laboratories, 200 percent of the allowable amount under Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on January 1 of the year in which ~~at the time~~ the services, supplies, or care was rendered and for the area in which such services were rendered, which shall apply throughout the remainder of the year notwithstanding any subsequent changes made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply any limitation on the number of treatments or other utilization

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limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. ~~2.~~ must reimburse a provider who lawfully provided care or treatment under the scope of his or her license~~,~~ regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

4.~~5.~~ If an insurer limits payment as authorized by subparagraph 1. ~~2.~~, the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. ~~With respect to~~ A bill or statement that does not ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs (c), ~~paragraph~~ (d), and (e);

e. Except for emergency treatment and care, if the insured failed to countersign a billing form or patient log related to such claim or charges. Failure to submit a countersigned billing

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form or patient log creates a rebuttable presumption that the insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the subject treatment and loss until the insurer is able to verify that the insured received the alleged treatment. As used in this sub-subparagraph, the term "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement;

f.~~e.~~ For any treatment or service that is upcoded, or that is unbundled if ~~when~~ such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer if~~, provided that~~ before doing so, the insurer contacts ~~must contact~~ the health care provider and discusses ~~discuss~~ the reasons for the insurer's change and the health care provider's reason for the coding, or makes ~~make~~ a reasonable good faith effort to do so, as documented in the insurer's file; and

g.~~f.~~ For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

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2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The ~~initial~~ list ~~shall be adopted by January 1, 2004, and~~ shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list must ~~of invalid diagnostic tests shall~~ be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may ~~shall~~ not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.

(c)~~1.~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant,

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the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may ~~shall~~ not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2.~~3.~~ For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph~~,~~ and the insurer is ~~shall not be~~ considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it

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receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Centers for Medicare and Medicaid Services ~~Health Care Finance Administration~~.

3.~~4.~~ Each notice of the insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.—Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the first billing cycle statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly

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completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must ~~shall~~, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A ~~No~~ statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills

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comply with this paragraph, and unless the statements or bills are ~~comply with this paragraph, and unless the statements or bills are~~ properly completed in their entirety as to all material provisions, with all relevant information being provided therein. If an insurer denies a claim due to a provider's failure to submit a properly completed form, the insurer shall notify the provider as to the provisions that were improperly completed, and the provider shall have 15 days after the receipt of such notice to submit a properly completed form. If the provider fails to comply with this requirement, the insurer is not required to pay for the services that were billed on the improperly completed form.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered. The services shall be described and listed on the disclosure and acknowledgement form in words readable by the insured. If the insured cannot read, the provider should verify, under penalty of perjury, that the services listed on the form were verbally explained to the insured before the insured signs the form. Listing CPT codes or other coding on the disclosure and acknowledgment form does not satisfy this requirement;

b. The insured, or his or her guardian, has both the right

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and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. An insurer is not considered to have been furnished with notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgment form is ~~shall be~~ furnished to the insurer pursuant to paragraph (4)(b)


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and sub-subparagraph 1.a. The disclosure and acknowledgement form may not be electronically furnished. A disclosure and acknowledgement form that does not meet the minimum requirements of sub-subparagraph 1.a. does not provide an insurer with notice of the amount of a covered loss or medical bills due.

6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt~~,~~ by rule~~,~~ a standard disclosure and acknowledgment form to ~~that shall~~ be used to fulfill the requirements of this paragraph~~, effective 90 days after such form is adopted and becomes final~~. ~~The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.~~

8. As used in this paragraph, the term "countersigned" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which describes the treatment rendered in a language readable by the insured ~~that is consistent with the services being rendered to the patient as~~

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~~claimed~~. Listing CPT codes or other coding on the patient log does not satisfy this requirement. The provider must provide copies of the patient log to the insurer within 30 days after receiving a written request from the insurer. Failure to maintain a patient log renders the treatment unlawful and noncompensable. The requirements ~~of this subparagraph~~ for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and ~~shall~~ reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, ~~then~~ the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

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(7) ~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request, and furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if~~; provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial. Such sworn statement must ~~shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of

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action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith.

1. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~ overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this subparagraph ~~paragraph~~, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

2. If an insured seeking to recover benefits pursuant to the no-fault law assigns the contractual right to those benefits or payment of those benefits to any person or entity, the assignee must comply with the terms of the policy. In all circumstances, the assignee is obligated to cooperate under the policy, which includes, but is not limited to, participating in an examination under oath. Examinations under oath may be recorded by audio, video, court reporter, or any combination

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thereof. Compliance with this paragraph is a condition precedent to recovery of benefits pursuant to the no-fault law.

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer which are reasonably obtainable by the claimant.

b. Before requesting that an assignee participate in an examination under oath, the insurer must send a written request to the assignee requesting all information that the insurer believes is necessary to process the claim, including the information contemplated under this subparagraph.

c. An insurer that, as a general practice, requests examinations under oath of an assignee without a reasonable basis is engaging in an unfair and deceptive trade practice.

(8)~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician’s findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the

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examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person fails to appear for ~~unreasonably refuses to submit to~~ an examination, the personal injury protection carrier is not required to pay ~~no longer liable~~ for ~~subsequent~~ personal injury protection benefits incurred after the date of the first requested examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to the recovery of benefits.

(9)~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—With respect to any dispute ~~under the provisions of ss. 627.730-627.7405~~ between the insured and the insurer under the no-fault law, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (11) and (16) ~~(10) and (15)~~.

(10)~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which include ~~shall include~~ health care providers licensed under chapter 457, chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

(a) The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for


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personal injury protection benefits~~,~~ if the requirements of this subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy. ~~If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section.~~

(b) If the insured elects the ~~to use a provider who is a~~ preferred provider option, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the policy may provide that charges for nonemergency services provided within this state are payable only if performed by members of the preferred provider network unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services, or unless the nonemergency services are rendered in the emergency room of a hospital licensed under chapter 395. ~~If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.~~

(c) The insurer shall provide each insured ~~policyholder~~ with a current roster of preferred providers in the county in

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which the insured resides at the time of purchasing ~~purchase of~~ such policy, and ~~shall~~ make such list available for public inspection during regular business hours at the insurer's principal office ~~of the insurer~~ within the state. The insurer may contract with a health insurer for the right to use an existing preferred provider network to implement the preferred provider option. Any other arrangement is subject to the approval of the Office of Insurance Regulation.

(11)~~(10)~~ DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, the claimant filing suit must provide the insurer ~~must be provided~~ with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b). A premature demand letter is defective and cannot be cured unless the court first abates the action or the claimant first voluntarily dismisses the action.

(b) The ~~notice~~ required notice must ~~shall~~ state that it is a "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.

2. The claim number or policy number upon which such claim was originally submitted to the insurer.

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim;

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and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (6)~~(5)~~(d) or the lost-wage statement previously submitted may be used as the itemized statement. ~~To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.~~

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if ~~so~~ requested by the claimant in the notice~~,~~ when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices must ~~pursuant to this subsection shall~~ be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection if ~~in the event~~ no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of

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10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If ~~the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent~~ the insurer determines not to pay any amount demanded, the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement is ~~shall be~~ treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for ~~a period of~~ 30 business days by the mailing of the notice required by this subsection.

(f) A demand letter that does not meet the minimum requirements set forth in this subsection or that is sent during the pendency of the lawsuit is defective. A defective demand letter cannot be cured unless the court first abates the action

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or the claimant first voluntarily dismisses the action.

(g) ~~(f)~~ An ~~Any~~ insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.

(h) If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter by certified or registered mail stating the exact amount that the claimant believes the insurer owes and why the claimant believes the amount paid is incorrect. The insurer has an additional 10 days after receipt of the second letter to issue any additional payment that is owed. The purpose of this provision is to avoid unnecessary litigation over miscalculated payments.

(i) Demand letters may not be used to request the production of claim documents or other records from the insurer.

Section 10. Paragraph (c) of subsection (7), and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third


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degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(10)~~(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(11) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

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(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

(a) "Insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.

(b) ~~(a)~~ "Property" means property as defined in s. 812.012.

(c) ~~(b)~~ "Value" has the same meaning ~~means value~~ as ~~defined~~ in s. 812.012.

Section 11. Subsection (1) of section 324.021, Florida Statutes, is amended to read:

324.021 Definitions; minimum insurance required.—The following words and phrases when used in this chapter shall, for the purpose of this chapter, have the meanings respectively ascribed to them in this section, except in those instances where the context clearly indicates a different meaning:

(1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~ is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use with such

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vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped. However, the term does ~~"motor vehicle" shall~~ not include a ~~any~~ motor vehicle as defined in s. 627.732~~(3)~~ if ~~when~~ the owner of such vehicle has complied with the no-fault law ~~requirements of ss. 627.730-627.7405, inclusive~~, unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

Section 12. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(k) Persons or entities practicing under s. 627.736(8) ~~627.736(7)~~.

Section 13. Paragraph (b) of subsection (1) of section 627.7401, Florida Statutes, is amended to read:

627.7401 Notification of insured's rights.—

(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive personal

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injury protection benefits under the ~~Florida Motor Vehicle~~ no-fault law. Such notice shall include:

(b) An advisory informing insureds that:

1. Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the insured notifies the insurer of a billing error, the insured may be entitled to a certain percentage of a reduction in the amount paid by the insured's motor vehicle insurer.

Section 14. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete lines 34 - 39

and insert:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; requiring short-form crash reports by a law enforcement officer to be maintained by the officer's agency; authorizing the investigation officer to testify at trial or

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provide an affidavit concerning the content of the reports; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; creating s. 626.9894, F.S.; providing definitions; authorizing the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for the organization and the organization's contract with the division; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; authorizing contributions from insurers; providing that any moneys received by the organization may be held in a separate depository account in the name of the organization; requiring the division to deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.4137, F.S.; requiring a claimant's request about insurance coverage to be appropriately served upon the disclosing entity; amending s. 627.730, F.S.; conforming a cross-reference; amending s. 627.731, F.S.; providing legislative intent with respect to the Florida Motor Vehicle No-Fault Law; creating s. 627.7311, F.S.; requiring the provisions, schedules, and procedures of the no-fault law to be implemented by insurers regardless of whether they are expressly stated in the policy; amending s. 627.732, F.S.; defining the terms

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"claimant" and "no-fault law"; amending s. 627.736, F.S.; conforming a cross-reference; adding acupuncturists to the list of authorized practitioners; requiring certain entities providing medical services to document that they meet required criteria; revising requirements relating to the form that must be submitted by providers; requiring an entity or clinic to file a new form within a specified period after the date of a change of ownership; revising provisions relating to when payment for a benefit is due; providing that an insurer's failure to send certain specification or explanation does not waive other grounds for rejecting an invalid claim; authorizing an insurer to obtain evidence and assert any ground for adjusting or rejecting a claim; providing that the time period for paying a claim is tolled during the investigation of a fraudulent insurance act; specifying when benefits are not payable; preempting local lien laws with respect to payment of benefits to medical providers; providing that a claimant that violates certain provisions is not entitled to any payment, regardless of whether a portion of the claim may be legitimate; authorizing an insurer to recover payments and bring a cause of action to recover payments; providing that an insurer may deny any claim based on other evidence of fraud; forbidding a physician, hospital, clinic, or other medical institution that fails to comply with certain provisions from billing the injured person or the

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insured; providing that an insurer has a right to conduct reasonable investigations of claims; authorizing an insurer to require a claimant to provide certain records; requiring a records review to be conducted by the same type of practitioner as the medical provider whose records are being reviewed or by a physician; specifying when the period for payment is tolled; authorizing an insurer to deny benefits if an insured, claimant, or medical provider fails to comply with certain provisions; forbidding the claimant from filing suit unless the claimant complies with the act; revising the insurer's reimbursement limitation; providing a limit on the amount of reimbursement; creating a rebuttable presumption that the insured did not receive the alleged treatment if the insured does not countersign the patient log; authorizing the insurer to deny a claim if the provider does not properly complete the required form within a certain time; requiring the provider to ensure that the insured understands the services being provided; specifying requirements for furnishing the insured with notice of the amount of covered loss; deleting an obsolete provision; requiring the provider to provide copies of the patient log within a certain time if requested by the insurer; providing that failure to maintain a patient log renders the treatment unlawful and noncompensable; revising requirements relating to discovery; authorizing the insurer to conduct a physical review of the treatment

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location; requiring the insured and assignee to comply with certain provisions to recover benefits; requiring the provider to produce persons having the most knowledge in specified circumstances; requiring the insurer to request certain information before requesting an assignee to participate in an examination under oath; providing that an insurer that requests an examination under oath without a reasonable basis is engaging in an unfair and deceptive trade practice; providing that failure to appear for scheduled examinations establishes a rebuttable presumption that such failure was unreasonable; authorizing an insurer to contract with a preferred provider network; authorizing an insurer to provide a premium discount to an insured who selects a preferred provider; authorizing an insurance policy to not pay for nonemergency services performed by a nonpreferred provider in specified circumstances; authorizing an insurer to contract with a health insurer in specified circumstances; revising requirements relating to demand letters in an action for benefits; specifying when a demand letter is defective; requiring a second demand letter under certain circumstances; deleting obsolete provisions; providing that a demand letter may not be used to request the production of claim documents or records from the insurer; amending s. 817.234, F.S.; conforming a cross-reference; providing civil penalties for fraudulent insurance claims; amending

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ss. 324.021, 456.057, and 627.7401, F.S.; conforming cross-references; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (1) of section 316.066, Florida Statutes, is amended to read:

316.066 Written reports of crashes.—

(1)(a) A Florida Traffic Crash Report, Long Form, must ~~is required to~~ be completed and submitted to the department within 10 days after ~~completing~~ an investigation is completed by the ~~every~~ law enforcement officer who in the regular course of duty investigates a motor vehicle crash:

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1. That resulted in death, ~~or~~ personal injury, or any indication of complaints of pain or discomfort by any of the parties or passengers involved in the crash;~~.~~

2. That involved one or more passengers, other than the drivers of the vehicles, in any of the vehicles involved in the crash;

3.~~2.~~ That involved a violation of s. 316.061(1) or s. 316.193; or~~.~~

4.~~3.~~ In which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if such action is appropriate, in the officer's discretion.

(b) In every crash for which a Florida Traffic Crash Report, Long Form, is not required by this section, the law enforcement officer may complete a short-form crash report or provide a short-form crash report to be completed by each party involved in the crash. Short-form crash reports prepared by the law enforcement officer shall be maintained by the officer's agency.

(c) The long-form and the short-form report must include:

1. The date, time, and location of the crash.

2. A description of the vehicles involved.

3. The names and addresses of the parties involved.

4. The names and addresses of all passengers in all vehicles involved in the crash, each clearly identified as being a passenger and the identification of the vehicle in which they were a passenger.

5.~~4.~~ The names and addresses of witnesses.

6.~~5.~~ The name, badge number, and law enforcement agency of the officer investigating the crash.

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7.~~6.~~ The names of the insurance companies for the respective parties involved in the crash.

(d)~~(c)~~ Each party to the crash must ~~shall~~ provide the law enforcement officer with proof of insurance, which must ~~to~~ be included in the crash report. If a law enforcement officer submits a report on the accident, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

(e)~~(d)~~ The driver of a vehicle that was in any manner involved in a crash resulting in damage to any vehicle or other property in an amount of $500 or more~~,~~ which ~~crash~~ was not investigated by a law enforcement agency, shall, within 10 days after the crash, submit a written report of the crash to the department or traffic records center. The entity receiving the report may require witnesses of the crash ~~crashes~~ to render reports and may require any driver of a vehicle involved in a crash of which a written report must be made ~~as provided in this section~~ to file supplemental written reports if ~~whenever~~ the original report is deemed insufficient by the receiving entity.

(f) The investigating law enforcement officer may testify at trial or provide a signed affidavit to confirm or supplement the information included on the long-form or short-form report.

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~~(c) Short-form crash reports prepared by law enforcement shall be maintained by the law enforcement officer's agency.~~

Section 2. Subsection (6) is added to section 400.991, Florida Statutes, to read:

400.991 License requirements; background screenings; prohibitions.—

(6) All forms that constitute part of the application for licensure or exemption from licensure under this part must contain the following statement:

INSURANCE FRAUD NOTICE.—Submitting a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, when seeking an exemption from licensure as a health care clinic, or when demonstrating compliance with part X of chapter 400, Florida Statutes, is a fraudulent insurance act, as defined in s. 626.989 or s. 817.234, Florida Statutes, subject to investigation by the Division of Insurance Fraud, and is grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Section 626.9894, Florida Statutes, is created to read:

626.9894 Motor vehicle insurance fraud direct-support organization.—

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

(a) "Division" means the Division of Insurance Fraud of the Department of Financial Services.

(b) "Motor vehicle insurance fraud" means any act defined

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as a "fraudulent insurance act" under s. 626.989, which relates to the coverage of motor vehicle insurance as described in part XI of chapter 627.

(c) "Organization" means the direct-support organization established under this section.

(2) ORGANIZATION ESTABLISHED.—The division may establish a direct-support organization, to be known as the "Automobile Insurance Fraud Strike Force," whose sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The organization shall:

(a) Be a not-for-profit corporation incorporated under chapter 617 and approved by the Department of State.

(b) Be organized and operated to conduct programs and activities; to raise funds; to request and receive grants, gifts, and bequests of money; to acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and to make grants and expenditures to or for the direct or indirect benefit of the division, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration, and the Department of Health to the extent that such grants and expenditures are to be used exclusively to advance the purpose of prosecuting, investigating, or preventing motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel if such grants and expenditures do not interfere with prosecutorial independence or otherwise create conflicts of interest which threaten the success of prosecutions.

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(c) Be determined by the division to operate in a manner that promotes the goals of laws relating to motor vehicle insurance fraud, that is in the best interest of the state, and that is in accordance with the adopted goals and mission of the division.

(d) Use all of its grants and expenditures solely for the purpose of preventing and decreasing motor vehicle insurance fraud, and not for the purpose of lobbying as defined in s. 11.045.

(e) Be subject to an annual financial audit in accordance with s. 215.981.

(3) CONTRACT.—The organization shall operate under written contract with the division. The contract must provide for:

(a) Approval of the articles of incorporation and bylaws of the organization by the division.

(b) Submission of an annual budget for the approval of the division. The budget must require the organization to minimize costs to the division and its members at all times by using existing personnel and property and allowing for telephonic meetings when appropriate.

(c) Certification by the division that the direct-support organization is complying with the terms of the contract and in a manner consistent with the goals and purposes of the department and in the best interest of the state. Such certification must be made annually and reported in the official minutes of a meeting of the organization.

(d) Allocation of funds to address motor vehicle insurance fraud.

(e) Reversion of moneys and property held in trust by the

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organization for motor vehicle insurance fraud prosecution, investigation, and prevention to the division if the organization is no longer approved to operate for the department or if the organization ceases to exist, or to the state if the division ceases to exist.

(f) Specific criteria to be used by the organization's board of directors to evaluate the effectiveness of funding used to combat motor vehicle insurance fraud.

(g) The fiscal year of the organization, which begins July 1 of each year and ends June 30 of the following year.

(h) Disclosure of the material provisions of the contract, and distinguishing between the department and the organization to donors of gifts, contributions, or bequests, including providing such disclosure on all promotional and fundraising publications.

(4) BOARD OF DIRECTORS.—The board of directors of the organization shall consist of the following seven members:

(a) The Chief Financial Officer, or designee, who shall serve as chair.

(b) Two state attorneys appointed by the Attorney General.

(c) Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.

(d) Two representatives of local law enforcement agencies, one of whom shall be appointed by the Chief Financial Officer, and one of whom shall be appointed by the Attorney General.

The officer who appointed a member of the board may remove that member for cause. The term of office of an appointed member expires at the same time as the term of the officer who

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appointed him or her or at such earlier time as the person ceases to be qualified.

(5) USE OF PROPERTY.—The department may authorize, without charge, appropriate use of fixed property and facilities of the division by the organization, subject to this subsection.

(a) The department may prescribe any condition with which the organization must comply in order to use the division's property or facilities.

(b) The department may not authorize the use of the division's property or facilities if the organization does not provide equal membership and employment opportunities to all persons regardless of race, religion, sex, age, or national origin.

(c) The department shall adopt rules prescribing the procedures by which the organization is governed and any conditions with which the organization must comply to use the division's property or facilities.

(6) CONTRIBUTIONS.—Any contributions made by an insurer to the organization shall be allowed as appropriate business expenses for all regulatory purposes.

(7) DEPOSITORY.—Any moneys received by the organization may be held in a separate depository account in the name of the organization and subject to the provisions of the contract with the division.

(8) DIVISION'S RECEIPT OF PROCEEDS.—If the division receives proceeds from the organization, those proceeds shall be deposited into the Insurance Regulatory Trust Fund.

Section 4. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

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627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant to this section shall be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Section 627.730, Florida Statutes, is amended to read:

627.730 Florida Motor Vehicle No-Fault Law.—Sections 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the "Florida Motor Vehicle No-Fault Law."

Section 6. Section 627.731, Florida Statutes, is amended to read:

627.731 Purpose; legislative intent.—The purpose of the no-fault law ~~ss. 627.730-627.7405~~ is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles required to be registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience.

(1) The Legislature finds that automobile insurance fraud remains a major problem for state consumers and insurers. According to the National Insurance Crime Bureau, in recent years this state has been among those states that have the highest number of fraudulent and questionable claims.

(2) The Legislature intends to balance the insured's interest in prompt payment of valid claims for insurance benefits under the no-fault law with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. To that end, the Legislature intends that the investigation and

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prevention of fraudulent insurance acts in this state be enhanced, that additional sanctions for such acts be imposed, and that the no-fault law be revised to remove incentives for fraudulent insurance acts. The Legislature intends that the no-fault law be construed according to the plain language of the statutory provisions, which are designed to meet these goals.

(3) The Legislature intends that:

(a) Insurers properly investigate claims, and as such, be allowed to obtain examinations under oath and sworn statements from any claimant seeking no-fault insurance benefits, and to request mental and physical examinations of persons seeking personal injury protection coverage or benefits.

(b) Any false, misleading, or otherwise fraudulent activity associated with a claim render the entire claim invalid. An insurer must be able to raise fraud as a defense to a claim for no-fault insurance benefits irrespective of any prior adjudication of guilt or determination of fraud by the Department of Financial Services.

(c) Insurers toll the payment or denial of a claim, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act, as defined in s. 626.989, has been committed.

(d) Insurers discover the names of all passengers involved in an automobile accident before paying claims or benefits pursuant to an insurance policy governed by the no-fault law. A rebuttable presumption must be established that a person was not involved in the event giving rise to the claim if that person’s name does not appear on the police report.

(e) The insured’s interest in obtaining competent counsel

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must be balanced with the public's interest in preventing a no-fault system that encourages litigation by allowing for exorbitant attorney's fees. Courts should limit attorney fee awards so as to eliminate the incentive for attorneys to manufacture unnecessary litigation.

Section 7. Section 627.7311, Florida Statutes, is created to read:

627.7311 Implementation of no-fault law.—The provisions, schedules, and procedures authorized under the no-fault law shall be implemented by insurers and have full force and effect regardless of their express inclusion in an insurance policy, and an insurer is not required to amend its policy to implement such provisions, schedules, or procedures.

Section 8. Section 627.732, Florida Statutes, is reordered and amended to read:

627.732 Definitions.—As used in the no-fault law ~~ss. 627.730-627.7405~~, the term:

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or

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physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; or ~~nor does the term include~~ a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment may not ~~cannot~~ be used by patients who are not patients of the registered clinic ~~for medical treatment of services~~. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period ~~provided in this paragraph~~ may be extended for an additional 60

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days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(9) ~~(2)~~ "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(c) Not primarily for the convenience of the patient, physician, or other health care provider.

(10) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of this state, and any trailer or semitrailer designed for use with such vehicle, and includes:

(a) A "private passenger motor vehicle," which is any motor vehicle that ~~which~~ is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type.

(b) A "commercial motor vehicle," which is any motor vehicle that ~~which~~ is not a private passenger motor vehicle.

The term ~~"motor vehicle"~~ does not include a mobile home or any motor vehicle that ~~which~~ is used in mass transit, other than public school transportation, and designed to transport more

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than five passengers exclusive of the operator of the motor vehicle and that ~~which~~ is owned by a municipality, a transit authority, or a political subdivision of the state.

(11)~~(4)~~ "Named insured" means a person, usually the owner of a vehicle, identified in a policy by name as the insured under the policy.

(12) "No-fault law" means the Florida Motor Vehicle No-Fault Law codifed at ss. 627.730-627.7407.

(13)~~(5)~~ "Owner" means a person who holds the legal title to a motor vehicle; or, if ~~in the event~~ a motor vehicle is the subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.

(15)~~(6)~~ "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere.

(2)~~(7)~~ "Certify" means to swear or attest to being true or represented in writing.

(3) "Claimant" means the person, organization, or entity seeking benefits, including all assignees.

(5)~~(8)~~ "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can respond

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immediately to any emergencies if needed.

(6)~~(9)~~ "Incident," with respect to services considered as incident to a physician's professional service, for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means ~~such~~ services that are ~~must be~~ an integral, even if incidental, part of a covered physician's service.

(7)~~(10)~~ "Knowingly" means that a person, with respect to information, has actual knowledge of the information,~~;~~ acts in deliberate ignorance of the truth or falsity of the information,~~;~~ or acts in reckless disregard of the information.~~,~~ ~~and~~ Proof of specific intent to defraud is not required.

(8)~~(11)~~ "Lawful" or "lawfully" means in substantial compliance with all relevant applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.

(4)~~(12)~~ "Hospital" means a facility that, at the time services or treatment were rendered, was licensed under chapter 395.

(14)~~(13)~~ "Properly completed" means providing truthful, substantially complete, and substantially accurate responses ~~as~~ to all material elements of ~~to~~ each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as agreed by the parties.

(17)~~(14)~~ "Upcoding" means submitting ~~an action that submits~~ a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. The term does not include an

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otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

(16) ~~(15)~~ "Unbundling" means submitting ~~an action that submits~~ a billing code that is properly billed under one billing code, but that has been separated into two or more billing codes~~,~~ and would result in payment greater than the ~~in~~ amount that ~~than~~ would be paid using one billing code.

Section 9. Subsections (1) and (4) of section 627.736, Florida Statutes, are amended, subsections (5) through (16) of that section are redesignated as subsections (6) through (17), respectively, a new subsection (5) is added to that section, present subsection (5), paragraph (b) of present subsection (6), paragraph (b) of present subsection (7), and present subsections (8), (9), and (10) of that section are amended, to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 must ~~shall~~ provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(e),~~ to a limit of $10,000 for loss sustained by ~~any~~ such person as a

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result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses, charged pursuant to subsection (6), for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and for medically necessary ambulance, hospital, and nursing services. However, the medical benefits ~~shall~~ provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following ~~persons or entities~~:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under part III of chapter 401 which ~~ss. 401.2101-401.45 that~~ provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such ~~practitioner or~~ practitioners and the spouse, parent, child, or sibling of such ~~that practitioner or those~~ practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under part X of chapter 400 which ~~ss. 400.990-400.995 that~~ is:

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a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

6. An acupuncturist licensed under chapter 457.

If any services under this paragraph are provided by an entity or clinic described in subparagraph 3., subparagraph 4., or subparagraph 5., the entity or clinic must provide the insurer

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at the initial submission of the claim with a form adopted by the Department of Financial Services which documents that the entity or clinic meets applicable criteria for such entity or clinic and includes a sworn statement or affidavit to that effect. Any change in ownership requires the filing of a new form within 10 days after the date of the change in ownership. ~~The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.~~

(b) *Disability benefits.*—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.

(c) *Death benefits.*—Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection by~~ marriage, or to any person appearing to the insurer to be equitably entitled thereto.

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Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurers may not ~~insurer shall~~ require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such ~~required~~ benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An ~~Any~~ insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates ~~shall be deemed to have violated~~ part IX of chapter 626, and such violation constitutes ~~shall constitute~~ an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An~~; and any such~~ insurer committing such violation is ~~shall be~~ subject to the penalties afforded in such part, as well as those that are ~~which may be~~ afforded elsewhere in the insurance code.

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon the receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the Agency for Health Care Administration provides, pays, or becomes

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liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits are ~~under ss. 627.730-627.7405 shall be~~ subject to the provisions of the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by the no-fault law ~~ss. 627.730-627.7405~~.

(b) Personal injury protection insurance benefits paid pursuant to this section are ~~shall be~~ overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer.

(c) If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must ~~shall~~ include the

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name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. An insurer's failure to send an itemized specification or explanation of benefits does not waive other grounds for rejecting an invalid claim.

(d) A ~~However, notwithstanding the fact that written notice has been furnished to the insurer, Any~~ payment is ~~shall~~ not ~~be deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to establish~~ that the insurer is not responsible for ~~the~~ payment. An insurer may obtain evidence and assert any ground for adjustment or rejection of a ~~For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the~~ claim that is ~~was~~ unrelated, ~~was~~ not medically necessary, ~~or was~~ unreasonable, or submitted ~~that the amount of the charge was in excess of that permitted under, or~~ in violation of~~,~~ subsection (6) ~~(5). Such assertion by the insurer may be made~~ at any time, including after payment of the claim, ~~or~~ after the 30-day ~~time~~ period for payment set forth in ~~this~~ paragraph (b), or after the filing of a lawsuit.

(e) The 30-day period for payment is tolled while the insurer investigates a fraudulent insurance act, as defined in s. 626.989, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify the claimant in

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writing that it is investigating a fraudulent insurance act within 30 days after the date it has a reasonable belief that such act has been committed. The insurer must pay or deny the claim, in full or in part, within 90 days after the date the written notice of the fact of a covered loss and of the amount of the loss was provided to the insurer. However, no payment is due to a claimant that has violated paragraph (k).

(f) ~~(c)~~ Notwithstanding any local lien law, upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002~~(9)~~, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such ~~a~~ claim ~~from a physician or dentist who provided emergency services and care or who provided hospital inpatient care~~ may ~~then~~ be used by the insurer to pay other claims. The time periods specified in paragraph (b) for ~~required~~ payment of personal injury protection benefits are ~~shall be~~ tolled for the period of time that an insurer is required ~~by this paragraph~~ to hold payment of a claim that is not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not

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require an insurer to establish a claim reserve for insurance accounting purposes.

(g) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. However, interest on a payment that is overdue pursuant to paragraph (e) shall be calculated from the date the insurer denies payment. Interest is ~~shall be~~ due at the time payment of the overdue claim is made.

(h) ~~(e)~~ The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2. if~~, provided~~ the relative at the time of the accident is domiciled in the owner's household and is not ~~himself or herself~~ the owner of a motor vehicle with respect to which security is required under the no-fault law ~~ss. 627.730-627.7405~~.

4. Accidental bodily injury sustained in this state by any

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other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle if~~, provided~~ the injured person is not ~~himself or herself~~:

a. The owner of a motor vehicle with respect to which security is required under the no-fault law ~~ss. 627.730-627.7405~~; or

b. Entitled to personal injury benefits from the insurer of the owner ~~or owners~~ of such a motor vehicle.

(i)~~(f)~~ If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable is ~~shall be~~ as specified in subsection (1), and any insurer paying the benefits is ~~shall be~~ entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(j)~~(g)~~ It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(k)~~(h)~~ Benefits are ~~shall~~ not ~~be~~ due or payable to a claimant who knowingly: ~~or on the behalf of an insured person if that person has~~

1. Submits a false or misleading statement, document, record, or bill;

2. Submits false or misleading information; or

3. Has otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989.

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A claimant that violates this paragraph is not entitled to any personal injury protection benefits or payment for any bills and services, regardless of whether a portion of the claim may be legitimate. However, a claimant that does not violate this paragraph may not be denied benefits solely due to a violation by another claimant.

(l) Notwithstanding any remedies afforded by law, the insurer may recover from a claimant who violates paragraph (k) any sums previously paid to a claimant and may bring any available common law and statutory causes of action. A claimant has violated paragraph (k) ~~committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy,~~ if the fraud is admitted to in a sworn statement ~~by the insured~~ or ~~if it is~~ established in a court of competent jurisdiction. Any insurance fraud voids ~~shall void~~ all coverage arising from the claim related to ~~such fraud under the personal injury protection coverage of~~ the claimant ~~insured person~~ who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before ~~prior to~~ the discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~ recoverable by the insurer from the claimant ~~person~~ who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph. This paragraph does not preclude or limit an insurer's right to deny a claim based on other evidence of fraud or affect an insurer's right to plead

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and prove a claim or defense of fraud under common law. If a physician, hospital, clinic, or other medical institution violates paragraph (k), the injured party is not liable for, and the physician, hospital, clinic, or other medical institution may not bill the insured for, charges that are unpaid because of failure to comply with paragraph (k). Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

(5) INSURER INVESTIGATIONS.—An insurer has the right and duty to conduct a reasonable investigation of a claim. In the course of the insurer's investigation of a claim:

(a) Any records review need not be based on a physical examination and may be obtained at any time, including after reduction or denial of the claim.

1. The records review must be conducted by a practitioner within the same licensing chapter as the medical provider whose records are being reviewed unless the records review is performed by a physician licensed under chapter 458 or chapter 459.

2. The 30-day period for payment under paragraph (4)(b) is tolled from the date the insurer sends its request for treatment records to the date that the insurer receives the treatment records.

3. The insured, claimant, or medical provider may impose a reasonable, cost-based fee that includes only the cost of copying and postage and not the cost of labor for copying.

(b) In all circumstances, an insured seeking benefits under the no-fault law must comply with the terms of the policy, which includes, but is not limited to, submitting to examinations

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under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

(c) An insurer may deny benefits if the insured, claimant, or medical provider fails to:

1. Cooperate in the insurer's investigation;

2. Commits a fraud or material misrepresentation; or

3. Comply with this subsection.

(d) The claimant may not file suit unless and until it complies with this subsection.

(6) ~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) ~~1.~~ Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only ~~a reasonable amount pursuant to this section~~ for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment~~,~~ if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such charges may not exceed the reimbursement schedule under this paragraph ~~a charge be in excess of the amount the person or institution customarily charges for like services or supplies~~. ~~With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments~~

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~~accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.~~

1.~~2.~~ The insurer shall ~~may~~ limit reimbursement to no more than 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002~~(9)~~ provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, ~~supplies, and care,~~ 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For all other supplies

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and care, including durable medical equipment and care and services rendered by ambulatory surgical centers and clinical laboratories, 200 percent of the allowable amount under Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on January 1 of the year in which ~~at the time~~ the services, supplies, or care was rendered and for the area in which such services were rendered, which shall apply throughout the remainder of the year notwithstanding any subsequent changes made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. ~~2.~~ must reimburse a provider who lawfully provided care or treatment under the scope of his or her

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license~~,~~ regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

4.~~5.~~ If an insurer limits payment as authorized by subparagraph 1. ~~2.~~, the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. ~~With respect to~~ A bill or statement that does not ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs (c), ~~paragraph~~ (d), and (e);

e. Except for emergency treatment and care, if the insured failed to countersign a billing form or patient log related to such claim or charges. Failure to submit a countersigned billing form or patient log creates a rebuttable presumption that the insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the subject treatment and loss until the insurer is able to verify that the

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insured received the alleged treatment. As used in this sub-subparagraph, the term "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement;

f.~~e.~~ For any treatment or service that is upcoded, or that is unbundled if ~~when~~ such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer if~~, provided that~~ before doing so, the insurer contacts ~~must contact~~ the health care provider and discusses ~~discuss~~ the reasons for the insurer's change and the health care provider's reason for the coding, or makes ~~make~~ a reasonable good faith effort to do so, as documented in the insurer's file; and

g.~~f.~~ For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury

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covered by personal injury protection benefits under this section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~ ~~and~~ shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list must ~~of invalid diagnostic tests shall~~ be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may ~~shall~~ not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.

(c)~~1.~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may ~~shall~~ not bill the injured party for, charges

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that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

2.~~3.~~ For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph~~,~~ ~~:~~ and the insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Centers for Medicare

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and Medicaid Services ~~Health Care Finance Administration~~.

3.~~4.~~ Each notice of the insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.—Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the first billing cycle statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers

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must ~~shall~~, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A ~~No~~ statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are ~~comply with this paragraph, and unless the statements or bills are~~ properly completed in their entirety as to all material provisions, with all relevant information being

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provided therein. If an insurer denies a claim due to a provider's failure to submit a properly completed form, the insurer shall notify the provider as to the provisions that were improperly completed, and the provider shall have 15 days after the receipt of such notice to submit a properly completed form. If the provider fails to comply with this requirement, the insurer is not required to pay for the services that were billed on the improperly completed form.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered. The services shall be described and listed on the disclosure and acknowledgement form in words readable by the insured. If the insured cannot read, the provider should verify, under penalty of perjury, that the services listed on the form were verbally explained to the insured before the insured signs the form. Listing CPT codes or other coding on the disclosure and acknowledgment form does not satisfy this requirement;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

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d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. An insurer is not considered to have been furnished with notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgment form is ~~shall be~~ furnished to the insurer pursuant to paragraph (4)(b) and sub-subparagraph 1.a. The disclosure and acknowledgement form may not be electronically furnished. A disclosure and acknowledgement form that does not meet the minimum requirements of sub-subparagraph 1.a. does not provide an insurer with notice

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of the amount of a covered loss or medical bills due.

6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt~~,~~ by rule~~,~~ a standard disclosure and acknowledgment form to ~~that shall~~ be used to fulfill the requirements of this paragraph~~, effective 90 days after such form is adopted and becomes final~~. ~~The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.~~

8. As used in this paragraph, the term "countersigned" or "countersignature" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which describes the treatment rendered in a language readable by the insured ~~that is consistent with the services being rendered to the patient as claimed~~. Listing CPT codes or other coding on the patient log does not satisfy this requirement. The provider must provide copies of the patient log to the insurer within 30 days after receiving a written request from the insurer. Failure to

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maintain a patient log renders the treatment unlawful and noncompensable. The requirements ~~of this subparagraph~~ for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and ~~shall~~ reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, ~~then~~ the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(7)~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which

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a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request, and furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if~~; provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial. Such sworn statement must ~~shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this

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section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith.

1. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~ overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this subparagraph ~~paragraph~~, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

2. If an insured seeking to recover benefits pursuant to the no-fault law assigns the contractual right to those benefits or payment of those benefits to any person or entity, the assignee must comply with the terms of the policy. In all circumstances, the assignee is obligated to cooperate under the policy, which includes, but is not limited to, participating in an examination under oath. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof. Compliance with this paragraph is a condition precedent to recovery of benefits pursuant to the no-fault law.

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having

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the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer which are reasonably obtainable by the claimant.

b. Before requesting that an assignee participate in an examination under oath, the insurer must send a written request to the assignee requesting all information that the insurer believes is necessary to process the claim, including the information contemplated under this subparagraph.

c. An insurer that, as a general practice, requests examinations under oath of an assignee without a reasonable basis is engaging in an unfair and deceptive trade practice.

(8)~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may

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thereafter examine, him or her in respect to the same mental or physical condition. If a person fails to appear for ~~unreasonably refuses to submit to~~ an examination, the personal injury protection carrier is not required to pay ~~no longer liable~~ for ~~subsequent~~ personal injury protection benefits incurred after the date of the first requested examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to the recovery of benefits.

(9)~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—With respect to any dispute ~~under the provisions of ss. 627.730-627.7405~~ between the insured and the insurer under the no-fault law, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (11) and (16) ~~(10) and (15)~~.

(10)~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which include ~~shall include~~ health care providers licensed under chapter 457, chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

(a) The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits~~,~~ if the requirements of this subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy. ~~If the insured elects to use a provider who is not a~~

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~~preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section.~~

(b) If the insured elects the ~~to use a provider who is a~~ preferred provider option, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the policy may provide that charges for nonemergency services provided within this state are payable only if performed by members of the preferred provider network unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services, or unless the nonemergency services are rendered in the emergency room of a hospital licensed under chapter 395. ~~If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.~~

(c) The insurer shall provide each insured ~~policyholder~~ with a current roster of preferred providers in the county in which the insured resides at the time of purchasing ~~purchase of~~ such policy, and ~~shall~~ make such list available for public inspection during regular business hours at the insurer's principal office ~~of the insurer~~ within the state. The insurer

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may contract with a health insurer for the right to use an existing preferred provider network to implement the preferred provider option. Any other arrangement is subject to the approval of the Office of Insurance Regulation.

(11) ~~(10)~~ DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, the claimant filing suit must provide the insurer ~~must be provided~~ with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b). A premature demand letter is defective and cannot be cured unless the court first abates the action or the claimant first voluntarily dismisses the action.

(b) The ~~notice~~ required notice must ~~shall~~ state that it is a "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.

2. The claim number or policy number upon which such claim was originally submitted to the insurer.

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (6) ~~(5)~~(d) or the lost-wage statement previously

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submitted may be used as the itemized statement. ~~To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.~~

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if ~~so~~ requested by the claimant in the notice~~,~~ when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices must ~~pursuant to this subsection shall~~ be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection if ~~in the event~~ no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If ~~the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet~~

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~~rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent~~ the insurer determines not to pay any amount demanded, the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement is ~~shall be~~ treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for ~~a period of~~ 30 business days by the mailing of the notice required by this subsection.

(f) A demand letter that does not meet the minimum requirements set forth in this subsection or that is sent during the pendency of the lawsuit is defective. A defective demand letter cannot be cured unless the court first abates the action or the claimant first voluntarily dismisses the action.

(g) ~~(f)~~ An ~~Any~~ insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under

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the insurance code.

(h) If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter by certified or registered mail stating the exact amount that the claimant believes the insurer owes and why the claimant believes the amount paid is incorrect. The insurer has an additional 10 days after receipt of the second letter to issue any additional payment that is owed. The purpose of this provision is to avoid unnecessary litigation over miscalculated payments.

(i) Demand letters may not be used to request the production of claim documents or other records from the insurer.

Section 10. Paragraph (c) of subsection (7), and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-~~

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~~insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(10)~~(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(11) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial

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Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

(a) "Insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.

(b) ~~(a)~~ "Property" means property as defined in s. 812.012.

(c) ~~(b)~~ "Value" has the same meaning ~~means value~~ as ~~defined~~ in s. 812.012.

Section 11. Subsection (1) of section 324.021, Florida Statutes, is amended to read:

324.021 Definitions; minimum insurance required.—The following words and phrases when used in this chapter shall, for the purpose of this chapter, have the meanings respectively ascribed to them in this section, except in those instances where the context clearly indicates a different meaning:

(1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~ is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use with such vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped.

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However, the term does ~~"motor vehicle" shall~~ not include a ~~any~~ motor vehicle as defined in s. 627.732~~(3)~~ if ~~when~~ the owner of such vehicle has complied with the no-fault law ~~requirements of ss. 627.730-627.7405, inclusive~~, unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

Section 12. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(k) Persons or entities practicing under s. 627.736(8) ~~627.736(7)~~.

Section 13. Paragraph (b) of subsection (1) of section 627.7401, Florida Statutes, is amended to read:

627.7401 Notification of insured's rights.—

(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive personal injury protection benefits under the ~~Florida Motor Vehicle~~ no-fault law. Such notice shall include:

(b) An advisory informing insureds that:

1. Pursuant to s. 626.9892, the Department of Financial

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Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the insured notifies the insurer of a billing error, the insured may be entitled to a certain percentage of a reduction in the amount paid by the insured's motor vehicle insurer.

Section 14. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; requiring short-form crash reports by a law enforcement officer to be maintained by the officer's agency; authorizing the investigation officer to testify at trial or provide an affidavit concerning the content of the reports; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; creating s. 626.9894, F.S.; providing definitions; authorizing the Division of Insurance Fraud to establish a direct-

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support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for the organization and the organization's contract with the division; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; authorizing contributions from insurers; providing that any moneys received by the organization may be held in a separate depository account in the name of the organization; requiring the division to deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.4137, F.S.; requiring a claimant's request about insurance coverage to be appropriately served upon the disclosing entity; amending s. 627.730, F.S.; conforming a cross-reference; amending s. 627.731, F.S.; providing legislative intent with respect to the Florida Motor Vehicle No-Fault Law; creating s. 627.7311, F.S.; requiring the provisions, schedules, and procedures of the no-fault law to be implemented by insurers regardless of whether they are expressly stated in the policy; amending s. 627.732, F.S.; defining the terms "claimant" and "no-fault law"; amending s. 627.736, F.S.; conforming a cross-reference; adding acupuncturists to the list of authorized practitioners; requiring certain entities providing medical services to document that they meet required criteria; revising requirements relating to the form

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that must be submitted by providers; requiring an entity or clinic to file a new form within a specified period after the date of a change of ownership; revising provisions relating to when payment for a benefit is due; providing that an insurer's failure to send certain specification or explanation does not waive other grounds for rejecting an invalid claim; authorizing an insurer to obtain evidence and assert any ground for adjusting or rejecting a claim; providing that the time period for paying a claim is tolled during the investigation of a fraudulent insurance act; specifying when benefits are not payable; preempting local lien laws with respect to payment of benefits to medical providers; providing that a claimant that violates certain provisions is not entitled to any payment, regardless of whether a portion of the claim may be legitimate; authorizing an insurer to recover payments and bring a cause of action to recover payments; providing that an insurer may deny any claim based on other evidence of fraud; forbidding a physician, hospital, clinic, or other medical institution that fails to comply with certain provisions from billing the injured person or the insured; providing that an insurer has a right to conduct reasonable investigations of claims; authorizing an insurer to require a claimant to provide certain records; requiring a records review to be conducted by the same type of practitioner as the medical provider whose records are being reviewed or

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by a physician; specifying when the period for payment is tolled; authorizing an insurer to deny benefits if an insured, claimant, or medical provider fails to comply with certain provisions; forbidding the claimant from filing suit unless the claimant complies with the act; revising the insurer's reimbursement limitation; providing a limit on the amount of reimbursement; creating a rebuttable presumption that the insured did not receive the alleged treatment if the insured does not countersign the patient log; authorizing the insurer to deny a claim if the provider does not properly complete the required form within a certain time; requiring the provider to ensure that the insured understands the services being provided; specifying requirements for furnishing the insured with notice of the amount of covered loss; deleting an obsolete provision; requiring the provider to provide copies of the patient log within a certain time if requested by the insurer; providing that failure to maintain a patient log renders the treatment unlawful and noncompensable; revising requirements relating to discovery; authorizing the insurer to conduct a physical review of the treatment location; requiring the insured and assignee to comply with certain provisions to recover benefits; requiring the provider to produce persons having the most knowledge in specified circumstances; requiring the insurer to request certain information before requesting an assignee to participate in an


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examination under oath; providing that an insurer that requests an examination under oath without a reasonable basis is engaging in an unfair and deceptive trade practice; providing that failure to appear for scheduled examinations establishes a rebuttable presumption that such failure was unreasonable; authorizing an insurer to contract with a preferred provider network; authorizing an insurer to provide a premium discount to an insured who selects a preferred provider; authorizing an insurance policy to not pay for nonemergency services performed by a nonpreferred provider in specified circumstances; authorizing an insurer to contract with a health insurer in specified circumstances; revising requirements relating to demand letters in an action for benefits; specifying when a demand letter is defective; requiring a second demand letter under certain circumstances; deleting obsolete provisions; providing that a demand letter may not be used to request the production of claim documents or records from the insurer; amending s. 817.234, F.S.; conforming a cross-reference; providing civil penalties for fraudulent insurance claims; amending ss. 324.021, 456.057, and 627.7401, F.S.; conforming cross-references; providing an effective date.

975042

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment to Amendment (552780)

Delete lines 177 - 182
and insert:
(b) Two state attorneys, one of whom shall be appointed by the Chief Financial Officer and one of whom shall be appointed by the Attorney General.
(c) Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.
(d) Two representatives of local law enforcement agencies, both of whom shall be appointed by the Chief Financial Officer.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1930
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1930 revises the Florida Motor Vehicle No-Fault Law (No-Fault Law) and related statutory provisions. The bill:

- Requires law enforcement officers to use the *Florida Traffic Crash Report—Long Form* in accidents involving passengers or passenger complains of pain or discomfort.
- Requires an "Insurance Fraud Notice" to be included within the application for health care clinic licensure.
- Establishes the Fight Auto Fraud Fund direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud.
- Requires requests for the disclosure of liability insurance information made to a self-insured corporation to be sent by certified mail to the entity's registered agent.
- Creates additional language expressing the Legislative intent of the Florida Motor Vehicle No-Fault Law.
- Defines "Claimant" to mean the person, organization, or entity seeking benefits, including all assignees.
- Revises provisions regarding Personal Injury Protection (PIP) policies offering a Preferred Provider (PPO) option for medical benefits. The bill authorizes motor vehicle insurers to contract with a health insurer to use its existing PPO network. The bill authorizes insurers to offer a discount to policyholders that select a policy that uses a PPO network to provide PIP benefits and specify that reimbursement will only be provided to network providers.
- Requires a clinic or entity that initially submits a PIP claim to an insurer to include a sworn affidavit that documents it is eligible to receive reimbursement.

- Requires the insured and a medical provider that accepts an assignment of no-fault benefits to comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO).
- Revises provisions related to demand letters.
    - The claimant filing suit must submit the demand letter.
    - A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - Demand letters may not be used to request record production from the insurer.
    - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are properly completed in their entirety.
- Requires health care providers to provide disclosures and patient logs to the injured person describing treatment in readable language. The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer.
- Clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.
- States that the insurer may define in the insurance policy what constitutes "reasonable proof" that the insurer is not liable to provide PIP benefits.
- Tolls the 30-day period for payment if the insurer reasonably believes a fraudulent insurance act was committed. The insurer must investigate and reach a claims decision within 120 days.
- Prohibits a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate.
- Prohibits a provider from billing the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts.
- Authorizes the insurer to require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer.
- Creates a rebuttable presumption that the injured party's failure to appear for a mental or physical examination was unreasonable. The insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination.
- Authorizes an insurer to conduct an on-site physical review and examination of the treatment location.
- Specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider.
- Prohibits a claimant from filing suit until it complies with the insurer's investigation.
- Provides that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement.

The bill is effective upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.991, 627.4137, 627.730, 627.731, 627.732, 627.736, 324, 324.021, 456.057, 627.7401, and 817.234.

This bill creates the following section of the Florida Statutes: 626.9894

II. Present Situation:

Florida Motor Vehicle No-Fault Law
Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[1] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation
- or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

[1] (Chapter 2007-324, L.O.F.)

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[4]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 hundred PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] The NICB defines a "questionable claim" as one in which indications of the behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[4] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies with law enforcement

description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division of Insurance Fraud have identified the following as sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,[5] that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers and that. A dissent in the case stated that the policy required the medical provider to submit to an examination under oath because the State Farm policy clearly stated that the medical provider must submit to an EUO under the State

[5] *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Demand Letter

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of an intent to initiate litigation. The notice must include an itemized statement detailing the exact amount and type of treatment asserted to be due. If the insurer pays the claim within 30 days (with interest and penalty) after receiving the demand letter then no action may be brought against the insurer. A suit may not be filed to obtain benefits and potentially collect attorney's fees until the end of this 30-day period.

Florida Uniform Crash Reports

Section 316.066, F.S., provides that a Florida Traffic Crash Report-Long Form must be completed and submitted to the Department within 10 days after an investigation by every law enforcement who, in the regular course of duty, investigates a motor vehicle crash that resulted in death or personal injury, that involved a violation of s. 316.061(1), F.S., or s. 316.193, F.S., and in which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if the action is appropriate, in the officer's discretion. For every crash for which a Florida traffic crash report long form is not required by s. 316.066, F.S., the law enforcement officer may complete a short form crash report or provide a short form crash report to be completed by each party involved in the crash.

Health Care Clinic Licensure

The Health Care Clinic Licensure Act (ss. 400.990-400.995, F.S.) was enacted by the 2003 Legislature for the purpose of preventing cost and harm to consumers by providing for the licensure, establishment and enforcement of basic standards for health care clinics. The definition of a health care "clinic" is expansive: "an entity at which 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."[6] However, the statute contains a multitude of exemptions from licensure. For instance, an entity owned by a Florida-licensed health care practitioner or by a Florida-licensed health care facility is exempt from the clinic licensure requirements. Furthermore, clinic exemptions are voluntary and the Agency for Health Care Administration (AHCA) has no statutory authority to verify that an entity qualifies for an exemption as claimed. As of January 20, 2011, there were 3,417 licensed health care clinics and 7,956 exemptions from licensure.

An applicant[7] for clinic licensure must submit to and pass a level 2 background screening pursuant to section 435.04, Florida Statutes, which requires taking fingerprints of each applicant and conducting a statewide criminal history check through the Department of Law Enforcement (FDLE) and national criminal history check through the Federal Bureau of Investigation (FBI).

[6] Section 400.9905(4), F.S.
[7] An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.

AHCA also reviews the finances of the proposed clinic and inspects the facility to verify that the proposed clinic complies with licensure requirements.

Direct Support Organizations

A direct service organization (DSO) collects funds through grants, donations and other sources, and distributes them to entities that will use the funds to further a legislative purpose. Florida's nondelegation doctrine derives from Article II, Section 3 of the Florida Constitution and prohibits one branch of government from encroaching on another branch's power and also prohibits any branch from delegating its constitutionally assigned powers to another branch.[8] Accordingly, a DSO cannot exceed its grant of statutory authority. Additionally, as a statutorily created organization, the DSO is subject to the Government in the Sunshine law under ch. 119, F.S.[9] Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within five months after the end of the fiscal year.[10]

III. Effect of Proposed Changes:

Section 1. Amends s. 316.066(1), F.S., to require the law enforcement officer investigating a motor vehicle crash to use the *Florida Traffic Crash Report—Long Form* if passengers are in any of the vehicles involved in the crash or any party or passenger complains of pain or discomfort. The long-form and short-form crash report must also list the names and addresses of all passengers involved in the crash and identify the vehicle where the passenger was located. The bill also specifies that the investigating officer may testify at trial or provide a signed affidavit to confirm or supplement the information on the long-form or short-form report.

Section 2. Amends s. 400.991(6), F.S., to require an "Insurance Fraud Notice" to be included within the application for health care clinic licensure and the application for an exemption from such licensure. The notice states that submitting a false, misleading, or fraudulent application or document when applying for health care clinic licensure, seeking an exemption from licensure, or demonstrating compliance with Part X of ch. 400, F.S. (the Health Care Clinic Act) is a fraudulent insurance act pursuant to s. 626.989, F.S. Such act is subject to investigation by the Division of Insurance Fraud and grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Creates s. 626.9894, F.S., establishing the Fight Auto Fraud Fund (Fund) direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The Fund will operate under a written contract with the Division of Insurance Fraud that requires the division to approve the Fund's articles of incorporation and bylaws, approve the annual budget, and certify that the Fund is complying with the terms of the contract

[8] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla.2005)
[9] *See* s. 119.011(2), F.S. (defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, *or other separate unit of government created or established by law including, for the purposes of this chapter*, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, *and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency*.") (emphasis added). See also *Crespo v. Florida Entertainment Direct Support Organization, Inc*., 674 So.2d 154 (Fla. 3rd DCA 1996).
[10] *See* ss. 11.45, 215.981, F.S.

and consistent with the goals of the DFS and best interests of the state. The Fund's contract with the Division of Insurance Fraud must provide for the allocation of monies to address motor vehicle fraud and the reversion of money and property held in trust by the Fund if it ceases to exist.

The Fund must be a not-for-profit corporation under ch. 617, F.S., and use all of its grants and expenditures solely to prevent and decrease motor vehicle insurance fraud. The fund is authorized to obtain money and property necessary to conduct its mission to allocate monies to address motor vehicle fraud in the following ways:

- Raise funds;
- Request and receive grants, gifts, and bequests of money; and
- Acquire, receive, hold, invest, and administer securities, funds, and real or personal property.

The Fund may make grants and expenditures that directly or indirectly benefit the Division of Insurance Fraud, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration (AHCA), and the Department of Health. Grants or expenditures made by the Fund must be used exclusively to prevent, investigate, and prosecute motor vehicle insurance fraud. Proper grants and expenditure include the salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel so long as the money does not interfere with prosecutorial independence or create conflicts of interest that threaten the prosecution's success.

Moneys received by the Fund may be held in a separate depository account in the Fund's name but are subject to the written contract with the Division of Insurance Fraud. The DFS is authorized to permit the Fund to use department property without expense and is granted rulemaking authority to prescribe the procedures and conditions for use of department property. Use of grants or expenditures to lobby is prohibited and the Fund is subject to an annual financial audit. All contributions made by an insurer are allowed as an appropriate business expense for regulatory purposes.

The Fund will have a 7-member board of directors consisting of the Chief Financial Officer (or designee), two state attorney's appointed by the Attorney General, two representatives of motor vehicle insurers appointed by the Chief Financial Officer, and two representatives of local law enforcement agencies (the CFO and Attorney General each get one appointment). Board-members serve a 4 year term, until the appointing officer leaves office, or until the member ceases to be qualified. The Fund's contract must provide criteria for use by the Fund's board of directors to evaluate the effectiveness of the Fund's spending to combat fraud.

Section 4. Amends s. 627.4137, F.S., which requires an insurer to provide a sworn disclosure setting forth information regarding each known policy providing liability insurance that may be available to pay a claim. The sworn statement must include the names of the insurer and each insured, the liability coverage limits, a copy of the policy, and a statement of all defenses the insurer reasonably believes it has. The bill requires requests for the disclosure made to a self-insured corporation must be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Amends s. 627.730, F.S., to clarify that s. 627.7407, F.S., is part of the Florida Motor Vehicle No-Fault Law.

Section 6. Amends s. 627.731, F.S., to create additional intent language for the Florida Motor Vehicle No-Fault Law. Current law states that the purpose of the no-fault law is to require motor vehicle insurance that provides specified benefits without regard to fault, to require the registration of motor vehicles, and create a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. The bill expands upon this language by stating that the Legislature intends to balance the insured's interest in prompt claim payment with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. Accordingly, the investigation and prevention of fraudulent insurance acts must be enhanced, additional sanctions for such acts must be imposed. The intent language also specifies how the Legislature intends the no-fault law to be interpreted. The no-fault law should be construed according to the plain language of the statutory provisions, which are designed to meet the goals specified by the legislature.

The Legislature provides two findings of fact within the intent language. The first is that automobile insurance fraud remains a major problem for state consumers, as evidenced by the National Insurance Crime Bureau's finding that the state is amongst those with the highest number of fraudulent and questionable clams. The second finding of fact is that the current regulatory process for health care clinics is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance.

The intent language concludes with statements of legislative intent regarding various provisions of the bill:

- The provisions, schedules and procedures authorized under the no fault law are effective regardless of their express inclusion in an insurance policy, and an insurer need not amend its policy to implement them.
- In order to properly investigate a claim, the insurer must be able to take pre-litigation examinations under oath and sworn statements of claimants and request mental and physical examinations of persons seeking PIP coverage or benefits.
- Any false, misleading, or fraudulent activity renders the entire claim invalid. Insurers must be able to raise fraud as a defense to a PIP claim when there has not been an adjudication of guilt or a determination of fraud by the DFS.
- Insurers should toll the payment or denial of a claim if the insurer reasonably believes that a fraudulent insurance act has been committed.
- A rebuttable presumption must be established that a person was not involved in a motor vehicle accident if that person's name is not in the police report.
- Courts should limit attorney fee awards to eliminate the incentive for attorneys to manufacture unnecessary litigation because the insured's interest in obtaining competent counsel should be balanced with the public's interest in a no-fault system that does not encourage unnecessary litigation.

Section 7. Amends s. 627.732, F.S., to define "claimant" and "No-Fault Law" within the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7407, F.S.). "Claimant" means the person, organization, or entity seeking benefits, including all assignees. Medical providers that accept an

assignment of benefits from the insured will be claimants under the No-Fault Law and subject to all statutory provisions related to a claimant under the law.

Section 8. Amends s. 627.736, F.S., which contains the statutory provisions governing the provision of Personal Injury Protection insurance coverage. The bill makes numerous revisions, which are detailed and explained herein.

Benefits – No-Fault Preferred Provider Networks [s. 627.736(10), F.S.]

Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" (PPO) option. However, if the insured uses an "out-of-network" provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law. The current PPO option does little to reduce PIP costs because there is no incentive for the insured to utilize network providers and thus little incentive for medical providers to contract with the PIP insurer. Additionally, many motor vehicle insurance carriers lack the expertise to create the medical provider network necessary to offer a preferred provider option.

The bill modifies the no-fault preferred provider option by authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider. If a premium discount is provided, the insurer may restrict reimbursement of non-emergency services to members of the preferred provider network unless there are no network providers within 15 miles of the insured's place of residence. The insurer may contract with a health insurer to use an existing preferred provider network, with any other arrangement subject to OIR approval.

Assignment of Benefits [s. 627.736(7)(b), F.S.]

The bill states that a medical provider that accepts an assignment of no-fault benefits from an insured, the medical provider and the insured must comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO). Compliance is a condition precedent to recovering benefits under the no-fault law.

Provider Billing Submissions – Notice of Licensure Compliance [s. 627.736(1)(a), F.S.]

A clinic or entity that initially submits a PIP claim to an insurer must include a sworn affidavit that documents that the entity or clinic is eligible to receive reimbursement for the treatment of bodily injuries covered by PIP insurance. The following entities must execute the affidavit:

- An entity that is wholly owned by one or more licensed physicians, chiropractors, or dentists or by the spouse, parent, child, or sibling of such medical practitioners.
- Wholly owned by a hospital or hospitals.
- A licensed health care clinic.

The affidavit must be executed on a form adopted by the DFS. If the entity or clinic changes ownership, a new sworn affidavit must be provided to the insurer within 10 days.

Provider Billing Submissions – Proper Submission of Billing Required for Insurer to Have Notice [s. 627.736(6)(d), F.S.]

The bill specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are submitted on an approved form, follow the proper coding requirements, and contain the professional license number of the provider. The remaining portions of statements and bills must be properly completed in their entirety. Current law contains a less stringent standard requiring bills and statements to be properly completed in their entirety "as to all material provisions, with all relevant information being provided therein."

Section 627.736(6)(c), F.S., generally requires health care providers to submit a statement of charges within 35 days of when the treatment was rendered. If a provider fails to submit the billing within the time frame, the insurer is not required to provide payment. Accordingly, if a provider fails to meet the bill's requirement to property submit a bill, the insurer will not be considered to have notice of the bill and the provider may be unable to obtain reimbursement for such services.

Provider Billing Submissions – Initial Disclosure Form and Patient Treatment Log [s. 627.736(6)(e), F.S.]

Current law requires a medical provider providing treatment for bodily injury covered by PIP insurance to obtain at the initial treatment a disclosure form of the insured's rights that details the treatment to be provided and is signed by the injured person and subsequently countersigned by the injured person verifying that the treatment was rendered. The disclosure and acknowledgement form is not required for emergency services or for ambulance transport and treatment. For subsequent treatments, the provider must maintain a patient log of services rendered in chronological order.

The bill states that the insurer does not have notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgement form is provided to the insurer with the countersignature of the insured and accurately describes the services rendered as required by s. 627.736(6)(e)1.a., F.S. The services rendered must be described on the form in a in a manner readable by the insured; listing billing codes is not allowed. The provider must determine whether the insured can read the disclosure. If not, the provider must verify, under penalty of perjury, that the services were verbally explained to the insured.

The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer. If the provider does not maintain a patient log, the treatment is unlawful and noncompensable. The patient log must describe subsequent services rendered in readable language; listing billing codes is not allowed.

Claim Payments – PIP Fee Schedule [s. 627.736(6)(a)2., F.S.]

The bill clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.

Claim Payments – Reasonable Proof [s. 627.736(4)(d), F.S.]

Under current law, a claims payment is not overdue if the insurer has reasonable proof that it is not responsible for payment. "Reasonable proof" is not defined in statute. The bill states that "reasonable proof" may be defined in the insurance policy and says an insurer may request information that will aid it in its claim investigation.

Insurer Investigation of Possible Fraudulent Insurance Acts [s. 627.736(4)(d), F.S.]

The 30-day period for payment is tolled during the insurer's investigation of a fraudulent insurance act, as defined in s. 626.989, F.S., for any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify that claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date the insurer has a reasonable belief the act was committed. The insurer must pay or deny the claim within 120 days.

Benefits are not due to a claimant who submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate. The insurer may recover sums previously paid to such claimants and bring a common law and statutory cause of action against the claimant if the fraud is admitted to in a sworn statement or established in court. Insurance fraud voids all coverage arising for the claim and all claims for attorneys fees, regardless of whether a portion of the claim is legitimate.

The insurer may recover any benefits or attorney's fees paid before the discovery of fraud. The paragraph does not preclude or limit the insurer's right to deny a claim on other evidence of fraud and to prove a claim or defense of fraud under common law. The injured party is not liable for fraudulent acts committed by a physician, hospital, clinic, or other medical institution. The provider not bill the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts in paragraph (j).

Insurer Investigations – Records Review [s. 627.736(5), F.S.]

The bill states that the insurer had the right and duty to reasonably investigate the claim. As part of the insurer's claim investigation, it may require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer. The insurer's choice of physician to conduct the records review is not limited by the physician's practice area or licensing chapter. The records review tolls the 30-day period for payment from the date the insurer sends a request for treatment records to the date the insurer receives the treatment records.

Insurer Investigations – Examinations Under Oath [s. 627.736(7)(b), F.S.]

A medical provider that accepts an assignment of benefits must submit to an examination under oath upon the request of the insurer. The provider must produce the persons having the most knowledge of the issues identified by the insurer in the EUO request. All claimants (the person

receiving treatment and the provider) must produce and provide for inspection all reasonably obtainable documents requested by the insurer. The EUO may be recorded by audio, video, or court reporter. Unreasonably requesting EUOs as a general practice is an unfair or deceptive trade practice.

Insurer Investigations – Mental & Physical Examination of Insured [s. 627.736(8), F.S.]

Current law authorizes the insurer to require an injured person to submit to a mental or physical examination whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future PIP insurance benefits. The bill specifies that the insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination. The bill also creates a rebuttable presumption that the injured party's failure to appear for an examination was unreasonable.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 53 Fla. L. Weekly S640 (Fla. 2010). In Custer, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Insurer Investigations – On-Site Inspection of Medical Provider [s. 627.736(7)(b), F.S.]

The bill authorizes each insurer to conduct an on-site physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and medical equipment used for services rendered within 10 days of the insurer's request.

Claim Denial – Grounds for Denying a PIP Claim or Refusing a Provider Billing [s. 627.736(5), F.S.]

The bill specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider. The insurer may deny a claim or reduce reimbursement if:

- The medical provider fails to maintain adequate records that would allow the insurer to obtain a records review.
- The insured, claimant, or medical provider fails to comply with the statutory requirements for a records review.
- The insured, claimant, or medical provider fails to cooperate in the insurer's investigation.
- The insured, claimant, or medical provider commits a fraud or material misrepresentation.

The claimant may not file suit:

- Until the records review is completed;

- If the claimant fails to cooperate with the insurer's claim investigation; or
- The claimant commits fraud or makes a material misrepresentation.

Under current law, subsection (6) specifies when the insurer or insured is not required to pay a claim or charges. The bill provides that the insurer or insured is not required to make a payment if the insured has not countersigned the billing forms and patient logs. The bill also states the insurer need not pay a bill or statement that does not comply with the billing requirements of subsections (c), (d), or (e). Subsection (c) generally requires the provider to submit a statement of charges to the insurer within 35 days of providing treatment. Subsection (d) requires the use of specified forms and practice codes when submitting a bill to the insurer. Subsection (e) directs the provider to require the insured person to execute a signed disclosure form during the initial treatment and to obtain the patient's countersignature on a treatment log that describes subsequent treatments.

Claim Denial – Insurer's Itemized Specification of Reduced or Denied Benefits [s. 627.736(4)(c), F.S.]

The bill states that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement. Current law requires an insurer that denies or only pays a portion of a PIP claim to provide an itemized specification of each item the insurer declined to pay or denied. The itemized specification includes information the insurer wants the claimant to consider related to the medical necessity of the treatment or to explain why the insurer was reasonable in reducing the charge, provided the information does not limit the introduction of evidence at trial.

Demand Letters [s. 627.736(11), F.S.]

Under current law, the claimant must provide a written demand letter specifying the PIP benefits and amounts that the claimant asserts are due under the policy prior to filing suit. If the insurer pays the overdue claim specified in the demand letter with interest and a 10 percent penalty, the claimant may not file suit. The bill modifies the demand letter requirement as follows:

- The claimant filing suit must submit the demand letter.
- A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - A defective demand letter cannot be cured unless the court abates the action or the claimant voluntarily dismisses the action.
    - If the insurer pays the benefits during abatement or dismissal, the insurer is not liable for attorney's fees.
- If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Demand letters may not be used to request record production from the insurer.
- Removes the requirement that a demand letter involving future treatment must include the insurer's notice of withdrawing payment for future treatment. Under current law, the insurer

may withdraw patient for a treating physician if the insurer retains a physician under that performs a mental or physical examination of the patient pursuant to s. 627.736(7), F.S., and the physician reports that the treatment is not reasonable, related, or necessary.

Section 9. Amends s. 324.021, F.S., by making technical, conforming changes to the definition of "motor vehicle" in the financial responsibility law.

Section 10. Amends s. 456.057(2)(k), F.S., by making a technical conforming change to a statutory reference.

Section 11. Amends s. 627.7401(1)(b), F.S., by making technical conforming changes to statutory references.

Section 12. Amends s. 817.234(7)(c), F.S., by making a technical conforming change to a statutory reference.

Section 13. The act is effective July 1, 2011.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

To the extent that the bill's provisions are effective in reducing motor vehicle insurance fraud, policyholders will benefit through a reduction in rates for such insurance.

C. Government Sector Impact:

The Fight Auto Fraud direct support organization may increase funding to the Division of Insurance Fraud and other law enforcement agencies to combat motor vehicle insurance fraud.

The Department of Highway Safety and Motor Vehicles states that the requirement to utilize the long-form traffic crash report when passengers are involved in an accident or there are indications that a party to the accident is experiencing pain or discomfort will create additional costs for the department. Based on historical trends, this change could increase the number of long form crash reports received by the department by approximately 90,000 per year. In 2009, the department received 76,258 short form reports that included one or more passengers involved in the accident. Based on estimates and the department's current contract for processing crash reports, the new requirements could cost the department to process the additional reports an estimated $104,687 per year. The department further estimates an additional 45,000 hours per year of time would be needed by officers of the state to complete the long form as opposed to the time it takes to complete the shot form.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

922322

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 70 - 359
and insert:
(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7407, where arbitration of an existing controversy is agreed to pursuant to s. 682.02 and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant

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to this section shall be sent by certified mail to the registered agent of the disclosing entity.

Section 3. Present subsections (10), (11), and (12) of section 817.234, Florida Statutes, are renumbered as subsections (11), (12), and (13), respectively, and a new subsection (10) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

And the title is amended as follows:

Delete lines 10 - 44

and insert:

amending s. 817.234, F.S.; providing civil penalties for fraudulent insurance claims involving motor vehicle insurance; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (8) of section 627.736, Florida Statutes, is amended, and subsections (17) and (18) are added to that section, to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an

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assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (10) and (15), and except that any attorney's fees recovered are limited to the lesser of $200 per billable hour or:~~.~~

(a) For a disputed amount less than $500, 15 times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of $5,000.

(b) For a disputed amount of $500 or more and less than $5,000, 10 times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of $10,000.

(c) For a disputed amount of $5,000 or more and up to $10,000, five times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of $15,000.

(17) CLASS ACTIONS.—Attorney's fees in a class action under ss. 627.730-627.7407 are limited to the lesser of $50,000 or three times the total of the disputed amount recovered in the class action proceeding.

(18) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the attorney's fees recovered under ss. 627.730-627.7407 shall be calculated without regard to any contingency risk multiplier.

Section 2. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 627.736, F.S.;

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limiting attorney's fees based on the disputed amount; limiting attorney's fees in class actions; providing that attorney's fees are calculated without regard to a contingency risk multiplier; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1694

INTRODUCER: Senator Richter

SUBJECT: Motor Vehicle Personal Injury Protection Insurance

DATE: March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1694 amends the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.). The bill requires any person seeking personal injury protection (PIP) benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). The bill also creates a rebuttable presumption that a claimant's failure to appear for an independent medical examination is unreasonable, and specifies that the insurer is not liable for any PIP benefits incurred after the date of the first request for examination.

The bill specifies that the Medicare fee schedule in effect on January 1 applies for the rest of the calendar year. The bill also clarifies the maximum PIP reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory and for medical care and services provided in an ambulatory surgical center.

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of $10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of $50,000 or three times the recovery. The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the arbitration of claims disputes over PIP benefits. The policy may require arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. The arbitrator's decision is binding on each party, but may be challenged by either party in Circuit Court. The arbitration challenge is limited to a review of the record and not de novo review. If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney's fees under s. 627.428, F.S., and interest will not accrue on the

amount in dispute during the litigation. The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration.

Written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

This bill substantially amends the following sections of the Florida Statutes: 26.012, 627.4137, 627.731, and 627.736.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[1] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

[1] *See* ch. 2007-324, L.O.F.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[4]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] The NICB defines a "questionable claim" as one in which indications of behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[4] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies.

referrals received by the Division during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division have identified the following sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by the insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co*., 37 So. 3d 329 (Fla. 5th DCA 2010), that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers. A dissent in the case stated that the *Shaw* policy clearly stated that the medical provider must

submit to an EUO under the State Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Attorney Fee Awards

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court engages in a "Lodestar" calculation, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[5] In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar[6]:

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the "Lodestar" amount in determining the fee award.[7] In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[8] A trial court has discretion regarding whether to apply a contingency risk multiplier, using the following criteria to determine whether a multiplier is necessary: (1) whether the relevant market requires a multiplier to obtain competent counsel; (2) whether the attorney could mitigate the risk of nonpayment; and (3) the amount involved, the results obtained, and the type of fee arrangement between the attorney and his client.[9] If the trial court determines that a multiplier is necessary, it may apply the following multipliers:

- A multiplier of 1 to 1.5 if success was more likely than not at the outset;
- A multiplier of 1.5 to 2.0 if the likelihood of success was approximately even at the outset;
- A multiplier of 2.0 to 2.5 if success was unlikely at the outset of the case.[10]

[5] See *Florida Patient's Compensation Fund v. Rowe*, 472 So. 2d 1145 (Fla. 1985).
[6] *See* R. Regulating Fla. Bar 4-1.5(b).
[7] See *Standard Guaranty Ins. Co. v. Quanstrom*, 555 So. 2d 828 (Fla. 1990).
[8] See *Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[9] *See supra* note 8 at 834.
[10] *See id.*

Florida Arbitration Code

The Florida Arbitration Code (ss. 682.01-682.22, F.S.) authorizes two or more parties to agree in writing to resolve controversies between the parties in arbitration proceedings governed by the provisions of the code.[11] Agreements to arbitrate under the Florida Arbitration Code are valid, enforceable, and irrevocable.[12] A party to an arbitration agreement may petition a court for an order directing the parties to proceed with arbitration, and court actions involving issues governed by the arbitration agreement must be stayed upon a request for such an order.[13]

The arbitration agreement governs the method of selecting arbitrators, in which the court selects the arbitrators if the agreement is silent on the issue or the method in the arbitration agreement fails.[14] If multiple arbitrators are selected, an umpire may also be selected that will render the arbitration award if the arbitrators are unable to agree. The arbitration hearing may be governed by the arbitration agreement or the arbitration code, the latter of which directs the arbitrators to provide notice of the hearing, review evidence, and render a decision.[15] The parties are entitled to be heard during the arbitration hearing, to present material evidence, to cross examine witnesses, and to have an attorney present. The arbitration award must be in writing and signed by the arbitrators.[16] Under the Florida Arbitration Code, the arbitration award may only be appealed in limited circumstances[17], and an arbitration award may only be vacated because it was procured by corruption, fraud, or undue means; the arbitrators or umpire were corrupt or partial; the arbitrators or umpire exceeded their powers or improperly refused to continue a proceeding or hear material evidence; or there was no valid agreement to arbitrate.[18]

In 2000, the Florida Supreme Court decided *Nationwide Mutual Fire Ins. Co. v. Pinnacle Medical, Inc.*, 753 So.2d 55 (Fla. 2000), which invalidated a statutory provision that required medical providers that receive an assignment of benefits under the No-Fault law to enter arbitration and prohibited such providers from pursuing a breach of contract claim in court. The Court declared that the arbitration provision violated the right of medical providers to access courts pursuant to article I, section 21 of the Florida Constitution. The court had previously declared a statute constitutional that directed parties to resolve disputes via arbitration before filing an action in circuit court because the statute provided for a trial de novo[19] in circuit court for a party who appealed the arbitration award.[20] The court also noted that a statutory requirement that the arbitration board's decision be presumed correct in the trial de novo would raise serious concerns regarding the constitutionality of such a provision.[21]

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[11] See s. 682.02, F.S.
[12] *See id.*
[13] *See* s. 682.03, F.S.
[14] *See* s. 682.05, F.S.
[15] *See* s. 682.06, F.S.
[16] *See* s. 682.09, F.S.
[17] *See* s. 682.20, F.S.
[18] *See* s. 682.13, F.S. See *District School Board of St. Johns County v. Timoney*, 524 So. 2d 1129, 1131 (Fla. 5th DCA 1998); See *Prudential-Bache Securities, Inc. v. Shuman*, 483 So. 2d 888 (Fla. 3d DCA 1986).
[19] A "trial de novo" is a new trial on appeal in which the court determines the matter anew, and the prior adjudication has no weight.
[20] See *Chrysler Corporation v. Pitsirelos*, 721 So. 2d 710, 713 (Fla. 1998).
[21] *See supra* note 21 at 714.

III. Effect of Proposed Changes:

Section 1. Amends s. 26.012(2), F.S., which specifies the original jurisdiction of Circuit Courts.

Circuit Court Jurisdiction of PIP Disputes

The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration. Pursuant to s. 34.01, F.S., county courts have original jurisdiction of civil actions in which the matter in dispute does not exceed $15,000, not including interest, costs, and attorney's fees, except for disputes that are within the exclusive jurisdiction of the circuit court. Currently, county courts have original jurisdiction over many disputes involving the No-Fault law because the amount in controversy is less than $15,000.

Section 2. Amends s. 627.4137, F.S., which requires liability insurers to disclose coverage information. The bill requires that written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

Section 3. Amends s. 627.731, F.S., which states the purpose of the Florida Motor Vehicle No-Fault Law.

Legislative Intent of the No-Fault Law

The bill provides a statement of legislative intent regarding the No-Fault Law. Three statements of legislative intent are provided:

- The provisions, schedules, and procedures authorized in the no-fault law are to be implemented by insurers and have full effect regardless of whether they are included in the insurance policy, and thus an insurer is not required to amend its policy form.
- Insurers should properly investigate claims. Accordingly, insurers may obtain examinations under oath and sworn statements from claimants seeking no-fault insurance benefits and may request mental and physical independent medical examinations of persons seeking PIP coverage or benefits.
- The insured's interest in obtaining competent counsel must be balanced with the public's interest in not encouraging PIP litigation because of exorbitant attorney's fees. Courts should limit attorney fee awards in order to eliminate incentives for attorneys to manufacture unnecessary litigation.

Section 4. Amends s. 627.736, F.S., governing PIP benefits. The bill makes the following changes:

Clarification of the PIP Fee Schedule

The PIP fee schedule utilizes the Medicare fee schedule in setting the maximum reimbursement that providers may obtain for many services and treatments. The bill requires use of the Medicare fee schedule in effect on January 1 of the year in which medical services, supplies, or care was provided.

The bill clarifies that the maximum reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory is 200 percent of the Medicare Part B fee schedule. The bill also clarifies that the maximum reimbursement for medical care and services provided in an ambulatory surgical center is 80 percent of the maximum reimbursement available under the workers' compensation fee schedule.

Compliance with Policy Terms and Submission to Examinations Under Oath

The bill requires any person seeking benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). Compliance with policy terms is a condition precedent to receiving benefits under the No-Fault law. However, insurers are prohibited from, as a general business practice, requesting EUOs in a manner inconsistent with the terms of the applicable insurance policy. When an insurer requests an EUO of a claimant or medical provider that has been assigned benefits by the claimant, the following statutory provisions apply:

- All claimants and medical providers must produce all documents requested by the insurer that are reasonably obtainable and allow them to be inspected.
- A medical provider that is requested to submit to an EUO must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination.
- The EUO may be recorded by audio, video, and court reporter.

The provision is intended to reverse the Florida Third District Court of Appeal's decision in *Shaw*, 37 So.3d 329.

Unreasonable Failure to Submit to a Medical Examination [s. 627.736(7), F.S.]

Current law authorizes an insurer to require that an injured PIP claimant submit to a physical or mental examination conducted by a physician of the insured's choosing. If a person unreasonably refuses to submit to an examination, the insurance carrier is no longer liable for subsequent PIP benefits. The bill clarifies that the carrier is not liable for any PIP benefits incurred after the date of the first request for examination. The bill also creates a rebuttable presumption that the claimant's failure to appear for the examination was unreasonable. The bill makes submission to a physical or mental examination a condition precedent to receiving benefits.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 35 Fla. L. Weekly S640 (Fla. November 4, 2010). In *Custer*, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Limitations on Attorney's Fees

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of $10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of $50,000 or three times the recovery.

The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

Arbitration of PIP Disputes

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the insurer or claimant to demand arbitration of claims disputes over PIP benefits. The policy may require the insurer or claimant to demand arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. Arbitration will be subject to the Florida Arbitration Code, except as otherwise provided in the statute.

The arbitration process will be as follows:

- *Demand for Arbitration* – The arbitration demand must be in writing and mailed to the insurer or claimant by certified mail.
- *Timeframe and Location of Arbitration*:
    - Arbitration may not be initiated until 30 days after the request for arbitration is received and 20 days after documents are received from the claimant and insurer.
    - Arbitration shall take place in the county where treatment was rendered. If treatment was rendered outside Florida, arbitration shall take place in the insured's county of residence unless the parties agree to another location.
- *Selection of the Arbitrator* – The parties shall mutually agree to the selection of an arbitrator within 20 days. If the parties cannot agree, the arbitrator will be selected by the chief judge of the circuit in which the arbitration is pending.
- *Document Discovery in Arbitration*:
    - The insurer may request in writing that the claimant make the entire file (including medical records) pertaining to the insured who is the subject of arbitration available for inspection.
    - The claimant may request in writing prior to the arbitration that the insurer make the evidence upon which it is relying in adjusting or rejecting the claim available for inspection or copying. The claimant may only discover items related to insurance coverage. Discovery is not available pertaining to issues of potential bad faith claims handling, nor is discovery available for privileged items, underwriting files, or documents the insurer does not intend to rely on as evidence supporting its adjustment or rejection of the claim.
- *The Arbitration Decision*:
    - The arbitrator's decision is binding on each party, unless challenged. The decision must be furnished in writing to each party.
    - The arbitrator's award may not exceed the applicable coverage limits remaining on the policy.
- *Attorney's Fees* – Attorney's fees may be recovered by the claimant, but are limited to three times the lesser of $10,000 or three times the amount recovered.

- *Circuit Court Challenge of the Arbitration Award* – Either party may challenge the arbitration decision by filing a complaint in circuit court enclosing a copy of the arbitration decision. The arbitration challenge is limited to a review of the record and not de novo review.
- *Limits on Attorney's Fees and Interest During an Arbitration Award Challenge* – If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney's fees under s. 627.428, F.S. In this circumstance interest on the amount in dispute will not accrue during the litigation.

Section 5. The act is effective upon becoming law.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill's authorization of insurance policies that require PIP disputes be submitted to arbitration may be unconstitutional pursuant to *Pinnacle Medical, Inc.*, 753 So. 2d 55. In *Pinnacle*, the Florida Supreme Court ruled unconstitutional a statute requiring medical providers to resolve PIP disputes through arbitration and prohibiting such providers from filing suit. Though the arbitration provision in this bill does not prohibit filing suit, the extremely limited grounds by which an arbitration award may be overturned (essentially a fraudulent proceeding) likely would be a violation of the right of access to courts guaranteed under the Florida Constitution. If appeal of arbitration via a trial de novo were provided, the arbitration provision should meet the standard articulated in the *Pinnacle* decision.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

244096

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/04/2011	.	
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The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraphs (f), (h), (j), and (l) of subsection (1) and paragraph (a) of subsection (2) of section 409.1671, Florida Statutes, are amended to read:

409.1671 Foster care and related services; outsourcing.—

(1)

(f)~~1.~~ The Legislature finds that the state has traditionally provided foster care services to children who <u>are</u> ~~have been~~ the responsibility of the state. As such, foster


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children have not had the right to recover for injuries beyond the limitations specified in s. 768.28. The Legislature has also determined that foster care and related services need to be outsourced ~~pursuant to this section~~ and that the provision of such services is of paramount importance to the state. The purpose for such outsourcing is to increase the level of safety, security, and stability of children who are or become the responsibility of the state.

1. One of the components necessary to secure a safe and stable environment for such children is for ~~that~~ private providers to maintain liability insurance. ~~As~~ Such~~,~~ insurance needs to be available and remain available to nongovernmental foster care and related services providers without the resources of such providers being significantly reduced by the cost of maintaining such insurance. To ensure that these resources are not significantly reduced, specified limits of liability are necessary for eligible lead community-based providers and subcontractors engaged in the provision of services previously performed by the Department of Children and Family Services.

2. The Legislature further finds that, by requiring the following minimum levels of insurance, children in outsourced foster care and related services will gain increased protection ~~and rights of recovery in the event of injury than provided for in s. 768.28~~.

(h) Other than an entity to which s. 768.28 applies, any eligible lead community-based provider~~, as defined in paragraph (e),~~ or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of $500,000 ~~$1 million~~

per occurrence or claim with a policy limit aggregate of~~/~~ $2 ~~$3~~ million ~~per incident~~ in general liability insurance coverage.

1. The eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities to obtain minimum bodily injury liability insurance in the amount of $100,000 per person ~~claim~~, $300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household ~~but only~~ while the automobiles are used in connection with the provider's business. The nonowned automobile coverage for the provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of $1 million per occurrence and $2 million in the aggregate for ~~in~~ nonowned automobile coverage.

2. In any tort action brought against ~~such~~ an eligible lead community-based provider or employee, net economic damages are ~~shall be~~ limited to $500,000 ~~$1 million~~ per occurrence, $1 million in the aggregate, ~~liability claim~~ and $100,000 per automobile claim, including, but not limited to, past and future


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medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action for economic damages, the total amount recoverable by all claimants is limited to no more than $1 million against the Department of Children and Family Services, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together. In any tort action brought against such an eligible lead community-based provider, noneconomic damages are ~~shall be~~ limited to $200,000 per occurrence and $500,000 in the aggregate. In any tort action for noneconomic damages, the total amount recoverable by all claimants is limited to no more than $1 million against the department, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together ~~claim~~.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76. The lead community-based provider is ~~shall~~ not ~~be~~ liable in tort for the acts or omissions of its subcontractors or the officers, agents, or employees of its subcontractors.

(j) Any subcontractor of an eligible lead community-based provider~~, as defined in paragraph (c),~~ which is a direct provider of foster care and related services to children and families, and its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability insurance coverage for a minimum of $500,000 ~~$1 million~~ per occurrence or claim with a policy limit


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aggregate of~~/~~ $2 ~~$3~~ million ~~per incident~~ in general liability insurance coverage.

1. The subcontractor of an eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per person ~~claim~~, $300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the subcontractor's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor is ~~shall be~~ primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of $1 million per occurrence and $2 million in the aggregate in nonowned automobile coverage.

2. In any tort action brought against such subcontractor or employee, net economic damages are ~~shall be~~ limited to $500,000 ~~$1 million~~ per occurrence, $1 million in the aggregate, ~~liability claim~~ and $100,000 per automobile claim, including,

but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action for economic damages, the total amount recoverable by all claimants is limited to no more than $2 million against the Department of Children and Family Services, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together. In any tort action brought against such subcontractor, noneconomic damages shall be limited to $200,000 per claim and $500,000 per incident. In any tort action for noneconomic damages, the total amount recoverable by all claimants is limited to no more than $1 million against the department, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76.

~~(l) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2)(a) The Department of Children and Family Services may contract for the delivery, administration, or management of

protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate. The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services~~ are of high quality and delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of an eligible lead community-based provider or the officers, agents, or employees of the provider, nor is the department liable in tort for the acts or omissions of the subcontractors of eligible lead community-based providers or the officers, agents, or employees of its subcontractors. The department may not require an eligible lead community-based provider or its subcontractors to indemnify the department for the department's own acts or omissions, nor may the department require an eligible lead community-based provider or its subcontractors to include the department as an additional insured on any insurance policy. A lead community-based provider may not require its subcontractors to add the lead community-based provider as an additional insured on a liability policy. The department shall ~~must~~ adopt written policies and procedures for monitoring the contract for the delivery of services by lead community-based providers. The ~~These~~ policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures

must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract ~~for services of lead community-based providers~~ are communicated to the director of the provider agency as expeditiously as possible.

Section 2. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to community-based care providers; amending s. 409.1671, F.S.; decreasing the requisite amount of insurance coverage for lead community-based providers and their subcontractors; decreasing the total amount of economic and noneconomic damages recoverable from the Department of Children and Family Services, the lead agencies, and all subcontractors; providing immunity from liability for the department for acts or omissions of a community-based provider or subcontractor, or the officers, agents, or employees thereof; prohibiting the department from requiring the lead agency to indemnify the department or for a subcontractor from requiring its subcontractors to add the lead agency as an additional insured; providing an

effective date.

WHEREAS, lead community-based providers were established to provide foster care and related services, and

WHEREAS, the goal of establishing these providers was to strengthen the support and commitment of communities to the reunification of families and the care of children and families and to increase the efficiency and accountability of providers, and

WHEREAS, lead community-based providers provide services identical to those previously provided by the Department of Children and Family Services, which was protected when delivering those services by the state’s sovereign immunity limits, and

WHEREAS, the costs of litigation and attorney’s fees diminishes the resources available to the children and families served by lead community-based providers, and

WHEREAS, the Legislature finds that the limits of liability for lead community-based providers should be reviewed, NOW, THEREFORE,

466760

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 64 - 197

and insert:

(h) Other than an entity to which s. 768.28 applies, any eligible lead community-based provider~~, as defined in paragraph (e),~~ or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of $1 million per occurrence or claim with a policy limit aggregate of~~/~~ $2 ~~$3~~ million ~~per incident~~ in general liability insurance coverage.

1. The eligible lead community-based provider must also

require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per person ~~claim~~, $300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household ~~but only~~ while the automobiles are used in connection with the provider's business. The nonowned automobile coverage for the provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of $1 million per occurrence and $2 million in the aggregate for ~~in~~ nonowned automobile coverage.

2. In any tort action brought against ~~such~~ an eligible lead community-based provider or employee, net economic damages are ~~shall be~~ limited to $1 million per occurrence, $2 million in the aggregate, ~~liability claim~~ and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such an eligible lead community-based provider,

466760

noneconomic damages are ~~shall be~~ limited to $200,000 per occurrence and $400,000 in the aggregate ~~claim~~.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76. The lead community-based provider is ~~shall~~ not ~~be~~ liable in tort for the acts or omissions of its subcontractors or the officers, agents, or employees of its subcontractors.

(j) Any subcontractor of an eligible lead community-based provider~~, as defined in paragraph (c),~~ which is a direct provider of foster care and related services to children and families, and its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability insurance coverage for a minimum of $1 million per occurrence or claim with a policy limit aggregate of~~/~~ $2 ~~$3~~ million ~~per incident~~ in general liability insurance coverage.

1. The subcontractor of an eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per person ~~claim~~, $300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the subcontractor’s casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the

466760

subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor is ~~shall be~~ primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of $1 million per occurrence and $2 million in the aggregate in nonowned automobile coverage.

2. In any tort action brought against such subcontractor or employee, net economic damages are ~~shall be~~ limited to $1 million per occurrence, $2 million in the aggregate, ~~liability claim~~ and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such subcontractor, noneconomic damages shall be limited to $200,000 per claim and $400,000 in the aggregate.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76.

~~(l) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set~~

~~amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2)(a) The Department of Children and Family Services may contract for the delivery, administration, or management of protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate. The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services~~ are of high quality and delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of an eligible lead community-based provider or the officers, agents, or employees of the provider, nor is the department liable in tort for the acts or omissions of the subcontractors of eligible lead community-based providers or the officers, agents, or employees of its subcontractors. The department may not require an eligible lead community-based provider or its subcontractors to indemnify the department for the department's own acts or omissions, nor may the department require an eligible lead community-based provider or its subcontractors to include the department as an additional insured on any insurance policy. A lead community-based provider may not require its subcontractors to add the lead community-based provider as an additional insured on a liability policy. The department shall ~~must~~ adopt

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129
130 ================ T I T L E A M E N D M E N T ================
131 And the title is amended as follows:
132 Delete lines 2 - 9
133 and insert:
134 An act relating to community-based care providers;
135 amending s. 409.1671, F.S.; decreasing the aggregate
136 amount of insurance coverage required for lead
137 community-based providers and their subcontractors;
138 providing immunity from liability for the department
139 for acts or omissions of a community-based provider or
140 subcontractor, or the officers, agents, or employees
141 thereof; prohibiting the department from requiring the
142 lead agency to indemnify the department or a
143 subcontractor from requiring its subcontractors to add
144 the lead agency as an additional insured; providing an
145 effective date.

370746

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete line 170

and insert:

(l) The limitations on liability specified in paragraphs (h) and (j) do not apply to an eligible lead community-based provider or subcontractor who compensates an executive employee, inclusive of any bonuses, at a level above the salary level of the Governor as established by law. Such lead community-based provider or subcontractor must maintain general liability insurance coverage for a minimum of $1 million per claim and $3 million per incident. ~~The Legislature is cognizant of the~~

370746

~~increasing costs of~~

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

And the title is amended as follows:

Delete line 5

and insert:

providers and subcontractors; increasing the requisite insurance coverage for certain providers and subcontractors; providing immunity from

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1500
INTRODUCER:	Senator Latvala
SUBJECT:	Foster Care Providers
DATE:	March 27, 2011
REVISED:	4/04/11

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Pre-meeting**
2.			CF	
3.			JU	
4.			BC	
5.				
6.				

I. Summary:

The Legislature established a community-based care system to strengthen community support and increase accountability for the state's child welfare program. The system began in 1996 when the Legislature required the establishment of a minimum of five pilot programs to privatize foster care and related services through contracts with established, community-based care (CBCs) agencies. By 2006, the Department of Children and Families (DCF) had implemented the community-based care model statewide by contracting with 20 CBCs or lead agencies.

Pursuant to s. 409.1671, F.S., the CBCs and their subcontractors are required to meet certain state and federal requirements, including the maintenance of specified levels of liability insurance. The bill provides the following changes relating to liability insurance and tort actions:

- The bill reduces the general liability insurance coverage requirements for CBCs and subcontractors to $500,000 per claim and a policy limit aggregate of $1.5 million from the current $1 million per claim and $3 million per incident.
- In tort actions against CBC lead agencies and subcontractors:
    - Limits economic damages recoverable per claimant to $500,000 and capped at $1.5 million for all claimants per incident from the current $1 million per liability claim. The bill also limits the total amount of economic damages recoverable by all claimants to $2 million against a CBC and all subcontractors involved in the same incident.

  - Limits noneconomic damages to $200,000 per claimant and $500,000 per incident. The bill also limits the total amount of noneconomic damages recoverable by all claimants to $1 million against a CBC and all subcontractors involved in the same accident.
- The bill revises the DCF's duties and responsibilities relating to contracted services of CBCs.
  - Revises the DCF's responsibility in regards to such contracts by requiring the DCF to use diligent efforts to ensure that such services are delivered in accordance with federal and state requirements. Under current law, the DCF is required to retain responsibility for the quality of contracted services and programs and to ensure that such services are delivered in accordance with federal and state requirements.
  - Provides that the DCF is not liable in tort for acts or omissions of a lead agency, or a subcontractor of the lead agency, or the officers, agents, or employees of the lead agency or subcontractor.
  - Prohibits the DCF from requiring a lead agency or a subcontractor to indemnify DCF against the DCF's own acts or omission.
  - Prohibits the DCF from requiring a lead agency or subcontractor to include the DCF as an additional insured on any insurance policy.

This bill substantially amends section 409.1671 of the Florida Statutes.

II. Present Situation:

Overview of Community-Based Care System in Florida

The Legislature created the community-based care system to strengthen community support and increase accountability for the child welfare program. The Legislature found that the purpose of such outsourcing "is to increase the level of safety, security, and stability of children who are or become the responsibility of the state."[1] Pursuant to s. 409.1671(e), F.S., the DCF is required to contract with a single agency, referred to as an "eligible lead community-based provider," for the provision of child protective services in a community. Under this current system, lead agencies are responsible for providing foster care and related services, including family preservation, emergency shelter, and adoption. A competent lead agency must:

- Have the ability to coordinate, integrate, and manage all child protective services in the designated community, and to ensure continuity of care.
- Provide directly, or contract for through a local network of providers, no more than 35 percent of all child protective services.
- Accept accountability for meeting all related state and Federal outcome standards, and serve all children referred, regardless of the level of funding allocated to the community by the state.

The DCF is responsible for program oversight, operating the abuse hotline, child protective investigations, and the provision of child welfare legal services. Pursuant to s. 409.1671(2)(a), F.S., the DCF is responsible for contracting for the delivery, administration, or management of protective services, foster care, and other related services or programs, as appropriate. The DCF

[1] Section 409.1671(1)(f), F.S.

has the responsibility for the quality of contracted services and programs and is responsible for ensuring that services are delivered in accordance with applicable federal laws and regulations as well as state laws and contractual agreements. Notwithstanding the outsourcing of foster care and related services, the DCF retains custody of the children in foster care and remains responsible for the services they are provided.

Overview: Commercial General Liability and Professional Liability Insurance

A commercial general liability policy insures for bodily injury to a third party caused by the insured and loss damage to property owned by third parties caused by the insured. Typically, a general liability policy limits the amount the insurer will pay for each claim for each person (a per-occurrence limit) or the total amount for the policy period (an aggregate limit). Professional liability insurance provides coverage for claims arising from a professional's faulty services or failure to meet the standard of service expected under the circumstances.

An additional insured is a person added to a policy as an insured but not as a named insured. Generally, ISO[2] endorsements furnish coverage to the additional insured for liability arising out of the named insured's work, operations, or premises.[3] Once a party becomes an additional insured, the insurer is obligated to defend and indemnify that additional insured in accordance with the policy terms and conditions.[4]

In regards to defense costs, Rule 69O-167.007 F.A.C., clarifies that defense cost must be in addition to the policy limits. This rule applies to all admitted carriers.

Insurance Requirements for Lead Agencies and Subcontractors

Section 409.1671(h) and (j), F.S., requires lead agencies and their subcontractors to provide general liability insurance coverage as well as automobile insurance coverage. Lead agencies and subcontractors are required to maintain a minimum level of general liability insurance of $1 million per claimant and $3 million per incident. In addition to the mandatory liability insurance limits, current law allows for a yearly increase of 5 percent in the conditional limitation on damages available to claimants to account for the annual increase in the cost of goods and services. Economic[5] damages per claimant are capped at $1,550,000.[6] Noneconomic[7] damages per claimant are capped at $310,000.[8]

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[2] The Insurance Services Office (ISO) is an organization that produces standard insurance forms. In Florida, forms and rates require approval by the Office of Insurance Regulation pursuant to the insurance code.

[3] What Does an Additional Insured Endorsement Cover? http://www.irmi.com/expert/articles/2000/postel07.aspx (last visited March 27, 2011).

[4] Last, William C., *Additional Insured Endorsements Revisited.* http://www.lhfconstructlaw.com/CM/Articles/Articles121.asp (Last visited March 27, 2011).

[5] *See, e.g.,* s. 766.202(3), F.S., defining "economic damages" as financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, past and future medical expenses, wage loss, loss of future earnings capacity, funeral expenses, and loss of prospective net accumulations of an estate.

[6] The original limit on economic damages was set at $1,000,000, in ch. 2009-206, L.O.F. The current limit on economic damages includes the annual 5 percent increase allowed by law.

[7] *See, e.g.,* s. 766.202(8), F.S., defining "noneconomic damages" as non-financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, pain and suffering, loss of support and services, loss of companionship or consortium, inconvenience, physical impairment, mental anguish, disfigurement, and loss of capacity for enjoyment of life.

[8] The original limit on noneconomic damages per claimant was set at $200,000 in ch. 2009-206, L.O.F. The current limit on noneconomic damages includes the annual 5 percent increase allowed by law.

In addition, lead agencies and subcontractors must maintain minimum bodily injury liability insurance coverage of $100,000 per claim and $300,000 per incident. Providers also must maintain $1,000,000 in non-owned automobile insurance coverage. This coverage is secondary to the primary insurance coverage of $100,000 per claim and $300,000 per incident that must be maintained by employees of lead agencies or subcontractors who use their personal vehicles to transport children and families in the course of providing services.

In addition to the statutory insurance requirements, the DCF also requires CBCs to maintain professional liability insurance and to name the DCF as an additional insured. The statutory and contractual coverage requirements do not appear to be risk-based since the minimum levels of coverage do not appear to take into consideration the size or volume of services provided by a particular CBC.

Commercial general liability insurance covers bodily injury and property damage arising out of an accident and generally excludes coverage for the abuse, neglect, and other types of errors and omissions claims to which lead community-based providers and subcontractors are exposed. Generally, some type of liability insurance or rider would cover these risks. The statute does not mandate such coverage. However, the availability and affordability of such coverage is indeterminate at this time.

The limits on liability provided for lead agencies and their subcontractors are not applicable if the lead agency or the subcontractor "acts in a culpably negligent manner or with willful and wanton disregard or unprovoked physical aggression when such acts result in injury or death or such acts proximately cause such injury or death…"[9] Culpable negligence is defined as "reckless indifference or grossly careless disregard of human life."[10] Further, the statute authorizes "a claim bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits" provided to lead agencies and their subcontractors.[11]

Each contract with a CBC provider is required to provide for the payment by the DCF to the provider of a reasonable administrative cost in addition to funding for the provision of services pursuant to s. 409.1671, F.S. Administrative costs would generally include operating costs such as insurance premiums.

Division of Risk Management of the Department of Financial Services

The division is responsible for the management of claims reported by or against state agencies for coverage under the self-insurance fund known as the "State Risk Management Trust Fund." The division has the responsibility of investigating, evaluating, negotiating, defending, and making appropriate disposition of claims/lawsuits filed against the state because of a negligent act or omission. Investigations of claims are conducted by staff and/or in concert with a contracted adjusting service. Defense of litigated claims is provided by the Attorney General's Office, contract law firms, or state agency attorneys.

[9] Section 4909.1671(1)(i) and (k), F.S.
[10] *Id.*
[11] Section 409.1671(1)(h) and (j), F.S.

General liability coverage is one of the types of coverage provided through the trust fund. For purposes of general liability coverage, the state is liable for damages for injury, death, or loss of property caused by the negligence of its employees, agents or volunteers while acting within the course and scope of their employment or responsibilities. The self-insurance coverage includes premises and operations, personal injury, and professional liability. In accordance with s. 768.28, F.S., the limits of liability (under the waiver of sovereign immunity law) are $100,000 per person's claim, $200,000 per occurrence for all claims.

The division provides coverage to the DCF for claims from foster children alleging negligence or civil rights violations relating to their care. Prior to the creation of CBC's and the privatization of foster care, the DCF provided all foster care services. The division does not provide coverage to the CBC's or their subcontractors. Consequently, the division does not have any data on how many claims the CBC's or their subcontractors have received or paid since their creation.

III. Effect of Proposed Changes:

Section 1 amends s. 409.1671, F.S., relating to liability insurance requirements and limits of liability for CBCs, CBC subcontractors, and the DCF.

The bill reduces the mandatory general liability insurance coverage requirement for lead agencies and subcontractors to $500,000 per claim and a policy limit aggregate of $1.5 million from $1 million per claim and $3 million per incident.

The limit on economic damages available to a claimant is reduced to $500,000 per claim and capped at $1.5 million for all claimants per incident from $1 million per liability claim. The total amount of economic damages recoverable by all claimants is limited to $2 million against a CBC and all subcontractors involved in the same incident.

The bill also limits noneconomic damages to $200,000 per claimant and $500,000 per incident. Currently, the noneconomic damages are limited to $200,000 per claim. The bill limits the total amount of noneconomic damages recoverable by all claimants to $1 million against a lead agency and all subcontractors involved in the same incident.

The bill repeals s. 409.1671(1)(l), F.S., thereby eliminating the 5 percent annual increase in the conditional limitations on economic and noneconomic damages.

The bill adds language to s. 409.1671(2)(a), F.S., to provide that the DCF is not liable in tort for the acts or omissions of a lead agency, or a subcontractor of a lead agency, or the officers, agents, or employees of a lead agency, or subcontractor of a lead agency. The DCF may not require a lead agency or subcontractor of a lead agency to indemnify the department for its own acts or omissions. Lastly, the department may not require a lead agency or subcontractor to include the department as an additional insured on any insurance policy.

The bill deletes legislative findings that the minimum levels of insurance were to be in excess of the rights of recovery under s. 768.28, F.S.

Section 2 provides that the bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Lower liability insurance limits should reduce insurance premiums for the CBCs and subcontractors. The elimination of the DCF as an additional insured may result in some indeterminate reduction in premiums for the CBCs.

The lower liability insurance requirements may limit the amount of money claimants can recover from CBCs and subcontractors.

C. Government Sector Impact:

According to the Division of Risk Management of the Department of Financial Services (DFS), the lower liability insurance requirements could result in foster children and their attorneys seeking more money from the state either in claims settlements or in claims bills. The DFS provided the following comments:

> "The bill reduces the amounts of general liability insurance a CBC is required to carry, it also reduces the amounts a claimant can recover for economic and non-economic damages. If a claimant can recover sufficient money from a CBC, they are less likely to press their claim against DCF and Risk Management or to file a claims bill against DCF."[12]

[12] Department of Financial Services Bill Analysis of SB 1500, dated March 9, 2011.

VI. Technical Deficiencies:

Commercial General Liability
According to the Office of Insurance Regulation,[13] typically general liability insurance is sold with an occurrence limit and an aggregate limit on the total cost of the claims occurring in an annual policy period. The bill requires a minimum of $500,000 per claim with a policy limit of $1.5 million. There is no standard legal definition of 'incident' within the typical context of general liability. These definitional issues can lead to litigation.

The additional limits of noneconomic damages on top of the economic damage limits for economic damage may create total costs on an occurrence that are higher than the legally mandated minimum per limits of insurance. That results in a situation where the damage caps do not match the required limits of insurance. Specifically, economic damages are capped at $500,000 per claim and noneconomic damages are capped at $200,000 per claim. The minimum general liability limit is $500,000 per claim.

VII. Related Issues:

Under current law, insurers of lead community-based providers' and subcontractors are not required to give the DCF written notice of any cancellation or nonrenewal and the lead community-based providers are not required to provide the DCF with copies of policies, endorsements, and certificates. Instead, the DCF contract with a CBC may require the insurer to give the DCF written notice of any intention to cancel or refuse to renew the policy at least 30 days prior to such action. The DCF needs notification of any cancellation or nonrenewal of a CBC policy and copies of policies, endorsements, and certificates in order to monitor compliance by the lead community-based providers and subcontractors with the statutory insurance coverage requirements. Gaps in coverage and other noncompliance by a CBC could result in liability exposure for the DCF. Pursuant to s. 627.4133, F.S., an insurer is required to provide notice to the named insured at least 45 days prior to nonrenewal, cancellation, or termination.

Although the bill does not amend the automobile insurance requirements, the provisions in the law for personal automobile policies does not match the language present in most personal automobile policies. The current law requires a minimum bodily injury liability insurance of $100,000 per claim and $300,000 per incident on personal automobiles used by staff of a CBC or subcontractor. The OIR notes that the typical personal automobile insurance requirements are stated in terms of a monetary limit per person and another monetary limit for all damages resulting from any one automobile accident.

VIII. Additional Information:

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

None.

[13] Office of Insurance Regulation Comments, dated April 4, 2011.

B. Amendments:

None.