HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1411 Motor Vehicle Personal Injury Protection Insurance
SPONSOR(S): Insurance & Banking Subcommittee, Boyd and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 2 N, As CS	Reilly	Cooper
2) Civil Justice Subcommittee			
3) Health & Human Services Committee			
4) Economic Affairs Committee			

SUMMARY ANALYSIS

At the January 26, 2011 meeting of the Insurance & Banking Subcommittee, which was devoted to private passenger motor vehicle insurance, industry experts testified about rampant fraud in Florida's personal injury protection (PIP, or no-fault motor-vehicle insurance) system and the cost of fraud to Florida motorists.

The bill creates the "Comprehensive Insurance Fraud and Prevention Act." The bill:

- Sets forth legislative findings as to motor vehicle insurance fraud.
- Requires long-form motor vehicle crash reports to include passenger information.
- Makes submission to an examination under oath (EUO) a condition precedent to eligibility for policy benefits or filing suit. Permits EUOs to be recorded.
- Creates a rebuttable presumption that a claimant's failure to appear for an examination is an unreasonable refusal to submit to examination. Makes submission to examination a condition precedent to recovery of policy benefits.
- Extends the PIP payment period to 120 days when the insurer reasonably believes that insurance fraud has been committed. Bars PIP claimants who submit false or misleading statements from receiving policy benefits and provides for insurers to recoup funds previously paid.
- Requires forms for licensure/exemption from health care clinic licensure to contain a fraud notice.
- Incorporates by reference all provisions of the Florida Motor-Vehicle No-Fault Law into every PIP insurance policy.
- Defines PIP claimants as any person, organization, or entity seeking benefits, including assignees.
- Requires certain medical entities seeking PIP reimbursement to provide the insurer with a sworn statement of compliance with eligibility requirements for reimbursement.
- Requires PIP insureds and medical providers to provide the insurer, upon request, with treatment and examination records for review by a physician.
- Clarifies the Medicare schedule to use when PIP reimbursement is Medicare based.
- For the first billing cycle, allows health care providers that timely provide notice of initiation of treatment to include treatment rendered up to 75 days before the postmark date on the mailed bill.
- Requires employers, upon insurer request, to provide a sworn statement of the pre- and post-injury earnings of a PIP claimant.
- Allows PIP insurers to offer a preferred provider policy option with a premium discount.
- Specifies civil penalties for claimants who make false or fraudulent insurance claims.

To the extent that the bill decreases fraudulent PIP claims, it will lower the cost of PIP insurance for Florida motorists.

The bill is effective July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Private Passenger Motor Vehicle Insurance in Florida

Private passenger motor vehicle insurance rates in Florida are among the highest in the country. For 2008, the estimated average expenditure for such insurance in Florida was $1,055; only the District of Columbia, Louisiana, and New Jersey had higher rates.[1] In 2009, Floridians spent over $11.9 billion on this insurance, making the Florida market the third largest in the nation.[2] More than 60 percent of the Florida market is written by ten insurance companies.[3]

The January 26, 2011 meeting of the Insurance & Banking Subcommittee of the Florida House of Representatives was devoted to private passenger motor vehicle insurance in Florida. Industry experts testified about rampant fraud in Florida's personal injury protection (PIP, or no-fault motor-vehicle insurance) system and the cost of fraud to Florida motorists. Staged accidents, health care clinic fraud, and persons falsely alleging to be passengers at the time of an accident were among the problems discussed.[4] The Subcommittee heard testimony that PIP costs are rising at 70 percent a year, that PIP fraud costs will approach $1 billion in 2011, and that the typical two-car family would pay up to $100 in added premiums to pay for PIP fraud, which was referred to as a "fraud tax" on consumers.[5]

The PIP System

Florida is one of 12 states[6] with no-fault motor vehicle[7] insurance provisions. PIP provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. PIP benefits are payable as follows:

- 80 percent of reasonable medical expenses.
- 60 percent of loss of income.
- Death benefit of $5,000 or the remainder of unused PIP benefits, whichever is less.

PIP provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries. Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:[8]

- Significant and permanent loss of an important bodily function.
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.
- Significant and permanent scarring or disfigurement.

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[1] Insurance Information Institute, "Auto Insurance," citing data of the National Association of Insurance Commissioners. Available at: http://www.iii.org/facts_statistics/auto-insurance.html (last accessed March 20, 2011).

[2] Florida Office of Insurance Regulation, "State of the Market: Property & Casualty Report" (December 17, 2010). On file with staff of the Insurance & Banking Subcommittee.

[3] *Id.* at 27. State Farm Mutual (19.8 percent market share) and Geico General (8 percent market share) are the largest writers of private passenger automobile insurance in Florida.

[4] The meeting packet is available at the Florida House of Representatives' website: http://www.myfloridahouse.gov/Sections/Committees/committeesdetail.aspx?SessionId=66&CommitteeId=2607 (last accessed March 20, 2011).

[5] See the Insurance Information Institute's presentation at the January 26th meeting of the Insurance & Banking Subcommittee.

[6] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance systems. See the Insurance Information Institute's update on "No-Fault Auto Insurance." Available at: http://www.iii.org/media/hottopics/insurance/nofault/ (last accessed: March 20, 2011).

[7] "Motor vehicle" is defined in s. 627.732, F.S., and includes private passenger motor vehicles and commercial motor vehicles.

[8] Section 627.737, F.S.

- Death.

Lawsuits for pain and suffering may commence only if the injuries meet these threshold levels.

Florida Traffic Crash Reports

Under s. 316.066, F.S., a crash report (long form) is required to be filed by a law enforcement officer with the Department of Highway Safety and Motor Vehicles only when the accident:

- Results in injury or death.
- Involves a hit and run or intoxicated driver.
- Results in a car being towed from the accident scene.

In other cases, a short-form crash report may be completed by a law enforcement officer or the parties involved in the accident.

Insurer Payment of PIP Claims and "Overdue" Benefits

PIP insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue.[9] Before filing a lawsuit for overdue PIP benefits, the aggrieved person must given the insurer written notice of intent to sue.[10] If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

Examinations of Insureds and Examinations Under Oath

In *Custer Medical Center v. United Automobile Insurance Co.*,[11] a passenger injured in an automobile accident failed to appear for two medical examinations requested by the insurer. At the time the requests were made, the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Florida Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer on the following grounds. Attendance at a medical examination is not a condition precedent to the existence of an automobile insurance policy. A dispute concerning attendance at a medical examination concerns an insured's right to receive "subsequent" PIP benefits pursuant to s. 627.736(7)(b), F.S., under an existing insurance policy, and is not a dispute about the policy's existence. Additionally, s. 627.737(7), F.S., provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits. Here, it was not shown that the injured passenger's failure to attend medical examinations constituted an "unreasonable refusal" to submit to examination. Further, the claim sought payment for medical services that had been provided before, and not after, the passenger failed to appear for examination.

Assignment of PIP Benefits

In *Shaw v. State Farm Fire and Casualty Co.*,[12] the 5th DCA held that policy language that required any person making a claim or seeking payment to submit to an examination under oath (EUO) did not require a health care provider who had been assigned PIP payment rights for services rendered to submit to an EUO. The 5th DCA based its decision on the following:

- The assignment of rights to the health care provider did not entail an assignment of duties.
- Section 627.736(6)(b), F.S., provides the mechanism for insurers to obtain information from health care providers concerning treatment and expenses.
- If there is a dispute regarding an insurer's right to discover facts from a health care provider, the insurer, under s. 627.736(6)(c), F.S., has the right to petition the court for a discovery order.

[9] Section 627.736(4)(b), F.S.
[10] Section 627.736(10), F.S.
[11] 2010 WL 4344089 (Fla.).
[12] 37 So.3d 329 (Fla. 5th DCA 2010).

As the en banc decision was not unanimous and had a potential wide ranging impact, the 5th DCA certified the following question of great public importance to the Florida Supreme Court:

> Whether a health care provider who accepts an assignment of no-fault insurance proceeds in payment of services provided to an insured can be required by a provision in the policy to submit to an examination under oath as a condition to the right of payment?

The Health Care Clinic Act

Part X of chapter 400, F.S., contains the Health Care Clinic Act (the act) (ss. 400.990-400.995, F.S.). The act was passed in 2003 to reduce fraud and abuse in the PIP insurance system.

Pursuant to the act, the Agency for Health Care Administration (AHCA) licenses health care clinics, ensures that such clinics meet basic standards, and provides administrative oversight. Any entity that meets the definition of a "clinic" ("an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services…") must be licensed as a clinic.[13] Every entity that meets the definition of a "clinic" must maintain a valid license with the AHCA at all times.[14] A clinic license lasts for a 2-year period. Each clinic must file, in its application for licensure, information regarding the identity of the owners, medical providers employed, and the medical director and proof that the clinic is in compliance with applicable rules. The clinic must also present proof of financial ability to operate a clinic. A level 2 background screening pursuant to chapter 435, F.S., is required of each applicant for clinic licensure. Each clinic must have a medical director or clinic director who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for specified activities on behalf of the clinic.

Although all clinics must be licensed with the AHCA, s. 400.9905(4), F.S., contains a listing of entities that are not considered a "clinic" for purposes of licensure. [15]

Effect of the Bill:

The bill, the "Comprehensive Insurance Fraud Investigation and Prevention Act," makes various changes to the Florida Motor Vehicle No-Fault Law (ss. ss. 627.730-627.7407, F.S.) and other laws to help combat PIP Fraud in Florida.

Legislative Findings and Intent

The bill states the Legislature's intent to balance the interests in the prompt payment of valid PIP claims with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. It also sets forth the following legislative findings:

- Motor vehicle insurance fraud is a major problem for consumers and insurers.
- The regulatory process for licensing health care clinics under the Health Care Clinic Act, part X, chapter 400, F.S., is not adequately preventing PIP fraud.

The Legislature also expresses its intent that:

- Insurers properly investigate claims and be allowed to obtain examinations under oath and mental and physical examinations of PIP claimants.
- False, misleading, or otherwise fraudulent activity associated with a PIP claim renders the entire claim invalid.

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[13] Section 400.9905(4), F.S.

[14] As of January 20, 2011, AHCA regulates 3,417 licensed health care clinics throughout Florida. See AHCA's presentation at the January 26, 2011 meeting of the Insurance & Banking Subcommittee. Available at the Florida House of Representatives' website.

[15] As of January 20, 2011, 7,956 entities held an exemption from health care clinic licensure. Since clinic exemptions are voluntary and there is no requirement to report the closure of a business, the number of exempt organizations that are still active is unknown. See AHCA's presentation at the January 26, 2011 meeting of the Insurance & Banking Subcommittee. Available at the Florida House of Representatives' website.

- The 30-day period within which insurers are required to pay PIP benefits be tolled when then insurer has a reasonable belief that a fraudulent insurance act has been committed.
- Insurers discover the names of all passengers involved in automobile accidents before paying claims or benefits. A person who is not named in an accident report is presumed not to have been involved in the accident. However, such presumption can be overcome by evidence to the contrary.

Crash Reports

The bill requires that long-form crash reports be filed with the Department of Highway Safety and Motor Vehicles in two additional circumstances:

1. When any person involved in a motor vehicle accident complains of pain or discomfort.
2. When a motor vehicle accident involves one or more passengers.

All crash reports are required to include the following information:

- The date, time, and location, of the crash.
- A description of the vehicles involved.
- The names and addresses of the parties involved and witnesses.
- The name, badge number, and law enforcement agency of the officer investigating the crash.
- The names of the respective parties' insurance companies.

Long-form crash reports are also required to include the names and addresses of all passengers involved in the crash, and clearly identify each such person as a passenger, including identifying the vehicle in which he/she was a passenger.

Investigating officers may testify at trial or provide a signed affidavit to confirm or supplement the information in any crash report.

Short-form crash reports prepared by law enforcement officers must be maintained by the officer's agency.

Payment of PIP Benefits

The 30-day period for payment of PIP benefits is tolled when the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer is required to provide the claimant with written notice that it is investigating a fraudulent insurance act within 30 days after the date of its reasonable belief. Such claims must be paid or denied, in whole or in part, by the insurer within 120 days after the insurer has received notice of the covered claim and the amount due.

The bill provides that no benefits are due or payable to or on behalf of a PIP claimant, even for portions of a claim that are legitimate, who:

- Submits a false or misleading statement, document, record, or bill.
- Submits any other false or misleading information.
- Has otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989, F.S.

Additionally, the insurer may recover any sums previously paid to such claimants and may bring legal action against the claimant.

If a physician, hospital, clinic, or medical institution is not eligible for benefits due to such misconduct, the injured party is not liable for, and the provider or entity may not bill the insured for, unpaid charges. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

Proof of Eligibility for PIP Reimbursement

The bill requires the following entities or licensed health care clinics, upon initial submission of a claim, to also submit to the insurer information, on a form approved by the Department of Financial Services, that documents its compliance with eligibility requirements for PIP reimbursement, and provide a sworn statement or affidavit to that effect:

- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parents, children, or siblings.
- An entity wholly owned by a hospital or hospitals.
- Licensed health care clinics that are accredited by a specified accrediting organization.
- Licensed health care clinics that have a medical director that is a Florida licensed physician, osteopath, or chiropractor; that have been continuously licensed for more than three years or are a publicly traded corporation; and that provide at least four of eight specified medical specialties.

Such entities and health care clinics are required to file a new form with the insurer within 10 days after any change in ownership.

Examinations Under Oath and Mental and Physical Examinations

The bill authorizes insurers to require PIP claimants to submit to an examination under oath (EUO) as often as reasonably requested and at any reasonable location. Submission to an EUO or a sworn statement is made a condition precedent to recovery under the policy or filing suit. The insurer is not liable for payment of PIP benefits if the claimant fails to fully and truthfully answer all questions asked, submits a false or misleading statement, document, record, or bill, or otherwise has committed or attempted to commit a fraudulent insurance act. The insurer is authorized to conduct the EUO outside of the presence of any other person seeking coverage. If an insurer requests an examination of a claimant that is in a hospital, clinic, or other medical institution, the claimant is required to produce those persons who have the most knowledge of the issues identified by the insurer in the notice of examination. At the EUO, claimants are required to provide the insurer with all requested documents and information. An EUO may be recorded, and the claimant, at his/her own expense, may have an attorney present. An insurer that, as a general business practice, requests EUOs without a reasonable basis commits an unfair insurance trade practice.

The failure to appear for an examination (mental or physical) is presumed to be an unreasonable refusal to submit to examination. The presumption, however, is rebuttable, and may be overcome by the claimant upon showing that the failure to attend was not an unreasonable refusal. When a claimant unreasonably refuses to submit to examination, the PIP insurer is not liable for benefits incurred after the date of the first request for examination. Submission to an examination is made a condition precedent to the recovery of PIP benefits.

Civil Penalties

In addition to criminal sanctions, a person convicted of violating s. 817.234, F.S. (“False and fraudulent insurance claims”) is subject to the following civil penalties:

- A fine of up to $5,000 for the first offense.
- A fine greater than $5,000 and up to $10,000 for a second offense.
- A fine greater than $10,000 and up to $15,000 for a third or subsequent offense.
- A fine of $15,000 to $50,000 for violation of s. 817.234(9), F.S. (relating to staged accidents and schemes to create documentation of a motor vehicle crash that did not occur).

Such civil penalties are to be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used for the investigation and prosecution of insurance fraud.

State attorneys are not prohibited from entering into written agreements in which a person charged with violating s. 817.234, F.S., does not admit to or deny the charges but consents to payment of the civil penalty.

Preferred Provider Policy Option

PIP insurers are authorized to enter into contracts with preferred providers to render PIP medical services. Insurers that offer a preferred provider option also are required to offer a nonpreferred provider option. The insurer may offer a premium discount, as approved in a rate filing, to policyholders that select the preferred provider option for PIP medical services. When a premium discount is provided, such policy may provide that charges for nonemergency services in Florida are payable only if performed within the insurer's preferred provider network, unless no member of the network whose practice includes the required services is located within 15 miles of the insured's residence. PIP Insurers are authorized to contract with another health care 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.

Health Care Clinics

The bill provides that all forms for health care clinic licensure, exemptions from licensure, or to demonstrate compliance with the Health Care Clinic Act must contain an insurance fraud notice. The statement provides notice that submission of a false, misleading, or fraudulent document is a criminal act or a fraudulent insurance act, subject to investigation by DIF, and is grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Miscellaneous

- Expands the definition of PIP claimant to include any person, organization, or entity seeking benefits, including assignees.
- For the first billing cycle only, permits health care providers that timely provide notice of initiation of treatment to include charges for treatment that was rendered up to 75 days before the postmark date on the statement of charges received by the insurer.
- States legislative intent that all provisions and schedules of the Florida Motor Vehicle No-Fault Law be incorporated by reference into every PIP insurance policy.
- Requires PIP insureds and medical providers to provide the insurer, upon request, with copies of treatment and examination records to be used by a physician for a records review, which is not required to be based on a physical examination and may be obtained by the insurer at any time. Tolls the 30-day period for payment of PIP claims from the date the insurer requests treatment records to the date the insurer receives the treatment records. Provides that claims may be denied or reduced if the medical provider fails to keep adequate records such that the insurer is unable to obtain a records review.
- Establishes that when PIP reimbursement is made under a Medicare-based schedule of maximum charges, that the applicable Medicare schedule in effect on January 1st is to be used throughout the year in calculating reimbursement, regardless of any subsequent changes in Medicare rates.
- Requires employers, upon request, to provide an insurer with a sworn statement of the earnings of a PIP insured since the time of the injury and for a reasonable period before the injury.

B. SECTION DIRECTORY:

Section 1. Provides that the bill may be cited as the "Comprehensive Insurance Fraud and Prevention Act;" sets forth legislative findings and intent.

Section 2. Amends s. 316.066, F.S., relating to written reports of motor vehicle crashes.

Section 3. Amends s. 400.991, F.S., requiring an insurance fraud notice on all forms for health care clinic licensure and exemption from licensure.

Section 4. Amends s. 627.730, F.S., providing that the Florida Motor Vehicle No-Fault Law is contained within ss. 627.730-627.7407, F.S.

Section 5. Amends s. 627.731, F.S.; providing legislative intent that all provisions, schedules, and procedures of the Florida Motor Vehicle No-Fault Law be incorporated by reference into all PIP insurance policies.

Section 6. Amends s. 627.732, F.S., defining "claimant" for purposes of the Florida Motor Vehicle No-Fault Law and amending other definitions.

Section 7. Amends s. 627.736, F.S., relating to reimbursement of certain entities under PIP; tolling of the 30-day PIP payment period when fraud is reasonably suspected; denying receipt of any benefits to claimants who commit fraud as to any portion of a claim; providing for insurers to obtain records for a records review; establishing the appropriate schedule to use for PIP reimbursement under a Medicare-based schedule of maximum charges; permitting certain charges to be included in a provider's first billing cycle; providing that a countersignature means a second verifying signature; providing that submission to an examination under oath (EUO) or a sworn statement is a condition precedent to PIP recovery or filing suit; permitting EUOs to be recorded; permitting onsite physical examination by the insurer of a provider's or medical facility's treatment location and equipment; requiring employers of PIP claimants to provide a sworn statement of the claimant's earnings before and after the injury upon insurer request; creating a rebuttable presumption that the failure to appear for an examination is a unreasonable refusal to submit to examination; providing that submission to examination is a condition precedent to recovery of PIP benefits; permitting PIP insurers to offer policyholders a preferred provider option and to offer a premium discount; allowing insurers to contract with other health insurers for the right to use an existing preferred provider network.

Section 8. Amends s. 817.234, F.S., providing for civil penalties.

Section 9. Amends s. 324.021, F.S., making technical changes.

Section 10. Amends s. 456.057, F.S., making conforming changes.

Section 11. Amends s. 627.7295, F.S., making conforming changes.

Section 12. Amends s. 627.733, F.S., making technical changes.

Section 13. Amends s. 627.734, F.S., making technical changes.

Section 14. Amends s. 627.737, F.S., making technical changes.

Section 15. Amends s. 627.7401, F.S., making conforming changes.

Section 16. Amends s. 627.7405, F.S., making technical changes.

Section 17. Amends s. 627.7407, F.S., making conforming changes.

Section 18. Amends s. 628.909, F.S., making conforming changes.

Section 19. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Highway Safety and Motor Vehicles estimates that enactment of the bill would result in its receipt of approximately 90,000 additional long-form crash reports per year. Based on its current contract for processing crash reports, the Department estimates that the maximum cost to process these reports would be $104,687 per year.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   To the extent that local law enforcement officers are required to complete and file additional crash reports, additional law enforcement resources would be utilized.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the bill decreases PIP fraud, the bill will lower the cost of fraud and decrease the cost of PIP insurance for Florida motorists.

D. FISCAL COMMENTS:

PIP fraud has been identified as a major problem in Florida and contributes to the high cost of motor vehicle insurance.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

There are some provisions in HB 1411 (the current bill) and HB 967 (“Personal Injury Protection Insurance”) that appear to conflict. For example, both bills require submission to insurer requests for EUOs. However, the current bill, unlike HB 967, does not require insurers to make a written request for information from assignees before requesting an EUO and does not entitle assignees to compensation

for time spent in an EUO. Also, the current bill defines PIP claimants to include insureds and assignees, whereas HB 967, at times, delineates between PIP insureds and assignees.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2011, the Insurance & Banking Subcommittee adopted one amendment (lines 224 to 341) that deleted the creation of a direct-support organization to fight motor vehicle insurance fraud.