The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 7012
INTRODUCER:	Children, Families, and Elder Affairs Committee
SUBJECT:	Mental Health
DATE:	November 13, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon		**CF Submitted as Comm. Bill/Fav**

I. Summary:

SB 7012 implements several measures related to suicide prevention. The bill broadens the scope of abilities and duties performed by both the Statewide Office of Suicide Prevention and the Suicide Prevention Coordinating Council, and adds new members to the Council. The bill adds new continuing education requirements related to suicide prevention for various health care practitioners, and requires certain health insurance plans to comply with federal statutes relating to mental health and substance abuse coverage in order to ensure that Floridians that are privately insured have adequate coverage to help prevent suicides. The bill provides civil immunity to persons who help or attempt to help others at imminent risk of suicide, and adds new training and staffing requirements for personnel at both public and charter schools. The bill also requires Baker Act receiving facilities to provide information on suicide prevention resources to minors being released from a facility.

The bill is not expected to have a significant fiscal impact and takes effect on July 1, 2020.

II. Present Situation:

Suicide is a major public health issue and a leading cause of death nationally, with complex causes such as mental health and substance use disorders, painful losses, exposure to violence, and social isolation.[1] Suicide rates increased in nearly every state from 1999 through 2016.[2] In 2017, suicide was the second leading cause of death nationwide for persons aged 10–14, 15–19, and 20–24.[3] After stable trends from 2000 to 2007, suicide rates for persons aged 10–24 increased 56% from 2007 (6.8 per 100,000 persons) to 2017 (10.6).[4]

[1] See, https://www.samhsa.gov/suicide-prevention, last visited November 7, 2019.
[2] Suicides Rising Across the U.S., June 7, 2018, available at: https://www.cdc.gov/vitalsigns/suicide/index.html (last visited November 6, 2019).
[3] Heron M. Deaths: Leading causes for 2017. National Vital Statistics Reports; Vol. 68 No 6. Hyattsville, MD: National Center for Health Statistics. 2019.
[4] Heron M., Curtin, S., *Death Rates Due to Suicide and Homicide Among Persons Aged 10-24: United States, 2007-2017*.U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Health Statistics, available at https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf (last visited November 6, 2019).

While suicide is often characterized as a response to a single event or set of circumstances, suicide is, in fact, the result of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors.[5] The factors that contribute to any particular suicide are diverse; therefore, it is generally believed that efforts related to prevention must incorporate multiple approaches.[6]

In Florida, the rate of suicides increased by 10.6% from 1996 to 2016.[7] According to the 2017 Florida Morbidity Statistics Report, the total number of deaths due to suicide in Florida was 3,187 in 2017, a slight increase from 3,122 in 2016.[8] Suicide was the eighth leading cause of death in Florida, and the suicide rate per 100,000 population was 15.5.[9] This is a slight increase from 2016 (15.4).[10] Suicide was the second leading cause of death for individuals within the 25-34 age group in 2017, similar to the national ranking of 2016, and the third leading cause of death for individuals within 15-24 age group; suicide was the fourth leading cause of death for individuals within the 5-14, 35-44, and 45-54 age groups.[11]

Statewide Office for Suicide Prevention

The Statewide Office of Suicide Prevention (Statewide Office) is housed within the Department of Children and Families (DCF).[12] Among other things, the Statewide Office must coordinate education and training curricula in suicide prevention efforts for law enforcement personnel, first responders to emergency calls, health care providers, school employees, and other persons who may have contact with persons at risk of suicide. [13]

The Statewide Office is required to operate within available resources but is allowed to seek and accept grants or funds from federal, state, or local sources to support the operation and defray the authorized expenses of the Statewide Office and the Suicide Prevention Coordinating Council.[14]

Suicide Prevention Coordinating Council

The Suicide Prevention Coordinating Council (Council) is located within DCF and develops strategies for preventing suicide and advises the Statewide Office regarding the development of a statewide plan for suicide prevention. A report on the plan is prepared and presented annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives.[15]

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[5] *Supra* at note 1.
[6] *Id*.
[7] *Supra* at note 2.
[8] Florida Department of Health, *2017 Florida Morbidity Statistics Report*, 2017, available at http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/data-and-publications/_documents/2017-annual-morbidity-statistics-report.pdf (last visited November 8, 2019).
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] Ch. 2011-51, L.O.F.; Section 14.2019, F.S.
[13] Section 14.2019, F.S.
[14] *Id*.
[15] Section 14.20195, F.S.

The Council is currently comprised of 27 voting members and 1 nonvoting member. 13 of the members are appointed by the director of the Statewide Office, 4 are appointed by the Governor, and 10 are state agency directors or their designees.

First-Episode Psychosis

The term "psychosis" is used to describe a condition that affects the mind and generally involves some loss of contact with reality. Psychosis can include hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not real), paranoia, delusions (believing something that is not real even when presented with facts), or disordered thoughts and speech.[16] Psychosis may be caused by medications or alcohol or drug abuse but can also be a symptom of mental illness or a physical condition.[17]

Psychosis affects people from all walks of life. Approximately three out of 100 people will experience psychosis at some time in their lives, often beginning when a person is in their late teens to mid-twenties.[18] Researchers are still learning about how and why psychosis develops, but it is generally thought to be triggered by a combination of genetic predisposition and life stressors during critical stages of brain development.[19] As such, adolescents are at a greater risk of developing psychosis when facing life stressors such as physical illness, substance use, or psychological or physical trauma.[20]

Early psychosis, known as "first-episode psychosis," is the most important time to connect an individual with treatment.[21] Studies have shown that it is common for a person to experience psychotic symptoms for more than a year before ever receiving treatment.[22] Reducing the duration of untreated psychosis is critical to improving a person's chance of recovery. The most effective treatment for early psychosis is coordinated specialty care, which uses a team-based approach with shared decision-making that focuses on working with individuals to reach their recovery goals.[23] Programs that provide coordinated specialty care are often called first-episode psychosis (FEP) programs.

Studies show that young people who engage in FEP programs have greater improvement in their symptoms, stay in treatment longer, are more likely to stay in school or working, and are more connected socially than those who receive standard mental care.[24]

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[16] National Institute of Mental Health, *Fact Sheet: First Episode Psychosis*, https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml (last visited November 7, 2019).
[17] *Id*.
[18] *Id*.
[19] National Alliance on Mental Illness, *What is Early and First-Episode Psychosis?*, July 2016, https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/What-is-Early-and-First-Episode-Psychosis.pdf (last visited November 7, 2019).
[20] Id.
[21] Id.
[22] *Id*.
[23] *Id*.
[24] *First Episode Psychosis Programs: A Guide to State Expansion*, National Alliance on Mental Illness, p. 4, (Feb. 2017), available at: https://www.nami.org/getattachment/Extranet/Advocacy/FEP-State-Advocacy-Toolkit/FEP-State-Advocacy-Guide.pdf (last visited November 7, 2019).

Veterans and Mental Health

Mental Health Among Veterans

According to the National Center for Post-Traumatic Stress Disorder, between 11-20 percent of veterans who served in Operations Iraqi Freedom and Enduring Freedom have Post-Traumatic Stress Disorder (PTSD) in a given year.[25] Statistics on depression in veterans vary, but it is estimated than an additional 2 to 10 percent return with major depression.[26] Additionally, 12 percent of Gulf War Veterans and 15 percent of Vietnam Veterans have PTSD, and up to 30 percent of Vietnam Veterans will have PTSD in their lifetime.[27]

The 2019 National Veteran Suicide Prevention Annual Report published by the United States Department of Veterans Affairs (USDVA) details veteran deaths from suicide from 2005 to 2017.[28] During that time span, veteran suicides increased from 5,787 in 2005 to 6,139 in 2017.[29] The annual number of veteran suicide deaths has exceeded 6,000 every year since 2008,[30] and the annual number of veteran suicide deaths increased by 129 from 2016 to 2017.[31]

Federal Mental Health Parity Laws

Commercial Plans

Prior to 1996, health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, the Mental Health Parity Act[32] (MHPA) was enacted in 1996, which requires parity of medical and surgical benefits with mental health benefits for annual and aggregate lifetime limits of large group plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act[33] (MHPAEA), which generally applies to large group health plans.[34] The MHPAEA expanded parity of coverage to include financial requirements, treatment limitations, and in- and out-of-network coverage if a plan provided coverage for mental illness. The MHPAEA also applies to the treatment of substance use disorders.[35] Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. The MHPAEA contains a cost exemption, which allows a group health plan to receive a waiver, exempting them from

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[25] National Center for PTSD, *How Common is PTSD? PTSD and the Military*, available at https://www.ptsd.va.gov/understand/common/common_veterans.asp (last visited November 6, 2019).
[26] RAND Center for Military Health Policy Research, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, at 54 (Terri Tanielian and Lisa H. Jaycox, Eds.) (2008), available at http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf (last visited November 6, 2019).
[27] *Supra* at note 21.
[28] U.S. Department of Veterans Affairs, *2019 National Veteran Suicide Prevention Annual Report*, 2019, available at https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf (last visited November 6, 2019).
[29] *Id*.
[30] *Id*.
[31] *Id*.
[32] Pub. L. No. 104-204.
[33] Pub. L. No. 110-343.
[34] See final regulations available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf (last viewed November 7, 2019).
[35] 45 CFR ss. 146 and 160.

some of the key requirements, if the plan demonstrates that costs increased at least 1 percent because of compliance.[36]

In 2010, the Patient Protection and Affordable Care Act[37] (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health insurance must provide coverage of 10 essential health benefits,[38] including coverage for mental health and substance use disorders for individual and small group qualified health plans. The final rule, implementing these provisions, generally requires health insurers offering health insurance coverage in the individual and small group markets to comply with the requirements of the MHPAEA regulations in order to satisfy the essential health benefit requirement.[39]

The Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[40] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[41] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[42]

The OIR reviews health insurance policies and contracts for compliance with MHPAEA. The OIR communicates any violations of MHPAEA to the insurer or HMO. If the insurer or HMO fails to correct the issue, the OIR would refer the issue to the appropriate federal regulator as a possible violation of federal law.

Coverage for Mental and Nervous Disorders

Section 627.668, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for mental and nervous disorders for an appropriate additional premium that would include benefits delineated in this section.

[36] Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or coverage or at least 1 percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last 1 year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least 1 percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.
[37] Pub. L. No.111-148, as amended by Pub. L. No. 111-152.
[38] 45 CFR s. 156.115.
[39] *See* 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).
[40] Section 20.121(3)(a), F.S.
[41] Section 641.21(1), F.S.
[42] Section 641.495, F.S.

Coverage for Substance Abuse

Section 627.669, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for substance abuse that would include benefits listed in the section.

Continuing Education Requirements for Health Care Practitioners

Compliance with continuing education (CE) requirements is a condition of renewal of license for health care practitioners. Boards, or the Department of Health (DOH) when there is no board, require each licensee to demonstrate competency by completing CEs during each licensure cycle. The number of required CE hours varies by profession. The requirements for CEs may be found in ch. 456, F.S., professional practice acts, administrative rules, or a combination of these references. Failure to comply with CE requirements may result in disciplinary action against the licensee, in accordance with the disciplinary guidelines established by the applicable board, or the DOH if there is no board.

The DOH or boards, when applicable, monitor heath care practitioner's compliance with the CE requirements in a manner required by statute. The statutes vary as to the required method to use. For example, DOH or a board, when applicable, may have to randomly select a licensee to request the submission of CE documentation;[43] require a licensee to a submit sworn affidavit or statement attesting that he or she has completed the required CE hours,[44] or perform an audit. Licensees are responsible for maintaining documentation of the CE courses completed.

The Good Samaritan Act

The "Good Samaritan Act," codified in s. 768.13, F.S., provides immunity from civil liability for damages to any person who:

- Gratuitously and in good faith renders emergency care or treatment either in direct response to declared state emergencies or at the scene of an emergency situation, without objection of the injured victim, if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.[45]
- Participates in emergency response activities of a community emergency response team if that person acts prudently and within the scope of his or her training.[46]
- Gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.[47]

The Good Samaritan Act, however, does not specifically address immunity from liability for individuals who attempt to render aid to others at risk of dying or attempting to die by suicide. Several states have implemented such measures in their Good Samaritan statutes in order to shield those who make a good faith effort to render aid from civil liability.[48]

[43] See s. 457.107, F.S.
[44] See ss.458.347(4)(e), 466.0135(6), 466.014, and 466.032(5), F.S.
[45] Section 768.13(2)(a), F.S.
[46] Section 768.13(2)(d), F.S.
[47] Section 768.13(3), F.S.
[48] Schiff, Damien, *Samaritans: Good, Bad and Ugly: A Comparative Law Analysis*, 11 Roger Williams Univ. L. Rev. 95 (2005).

Suicide Prevention Certified Schools

Section 1012.583, F.S., requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to develop a list of approved youth suicide awareness and prevention training materials that may be used for training in youth suicide awareness and prevention for school instructional personnel. The approved list of materials:[49]

- Must include training on how to identify appropriate mental health services and how to refer youth and their families to those services;
- May include materials currently being used by a school district if such materials meet any criteria established by the department; and
- May include programs that instructional personnel can complete through a self-review of approved youth suicide awareness and prevention materials.
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A school is considered a "Suicide Prevention Certified School" if it:

- Has at least two school-based staff members certified or otherwise deemed competent in the use of a DOE-approved suicide screening instrument; and
- Chooses to incorporate 2 hours of DOE-approved training materials and requires all of its instructional personnel to participate in the training.

III. Effect of Proposed Changes:

Section 1 amends s. 14.2019, F.S., adding veterans and service members to the list of stakeholders advocating suicide prevention that comprise the network of community-based programs developed by the Statewide Office to improve suicide prevention initiatives. The bill also requires the Statewide Office to coordinate education and training curricula in suicide prevention efforts for veterans and service members. The bill requires the Statewide Office to act as a clearinghouse for information and resources related to suicide prevention by disseminating evidence-based practices and by collecting and analyzing data on trends in suicide by various population demographics. The bill requires the Statewide Office to advise DOT on the implementation of evidence-based suicide deterrents when designing new infrastructure projects throughout the state.

Section 2 amends s. 14.20195, F.S., directing the Council to make findings and recommendations regarding suicide prevention specifically related to the implementation of evidence-based mental health awareness and assistance training programs and gatekeeper training throughout the state. The bill requires the Council to work with DCF to advise the public on the locations and availability of local behavioral health providers. The bill also adds three new members to the Council: one each from the Florida Medical Association, the Florida Osteopathic Medical Association, and Veterans Florida, the Florida Psychological Association, the Florida Psychiatric Society, and the Florida Florida Behavioral Health Association, the bill eliminates their individual memberships and replaces them with a single seat for the Florida Behavioral Health Association.Association of Managing Entities. Currently, the Florida Alcohol and Drug

[49] S. 1012.583(1), F.S.

Abuse Association and the Florida Council on Community Mental Health each occupy one spot on the council; because those organizations have merged to form the

Section 3 amends s. 334.044, F.S., requiring the Florida Department of Transportation to work with the Statewide Office in developing a plan to consider evidence-based suicide deterrents on all newly planned infrastructure projects throughout the state.

Section 4 amends s. 394.455, F.S., defining first episode psychosis (FEP) programs as evidence-based programs that use intensive case management, individual or group therapy, supported employment, family education and supports, and appropriate psychotropic medication to treat individuals 14 to 30 years of age who are experiencing early indications of serious mental illness, especially first-episode psychosis.

Section 5 amends s. 394.4573, F.S., establishing FEP programs as an essential element of a coordinated system of care and requires DCF to conduct an assessment of the availability of and access to FEP programs in the state, including any gaps in availability or access that may exist. This assessment must be included in DCF's annual report to the Governor and Legislature on the assessment of behavioral health services in the state. The bill also adds FEP programs to the elements of a coordinated system of care.

Section 6 amends s. 394.463, F.S., requiring facilities who hold and release Baker Act patients who are minors to provide information regarding the availability of mobile response teams, suicide prevention resources, social supports, and local self-help groups to the patient's guardian upon release.

Section 7 creates s. 456.0342, F.S., adding suicide prevention to the continuing education (CE) requirements for allopathic physicians, osteopath physicians, and nurses, effective January 1, 2022. Such licensees must complete two hours of CE courses on suicide risk assessment, treatment, and management. The bill requires the respective licensing board for each of the three professions to include the hours required for completion in the total hours of continuing education required by law for health care practitioners.

Section 8 amends s. 627.6675, F.S., requiring health insurers to offer benefits specified in the newly created s. 627.4193, F.S. The effective date of this section is January 1, 2021.

Section 9 transfers s. 627.668, F.S., and renumbers it as s. 627.4193, F.S., requiring insurers that issue, deliver, or provide comprehensive major medical individual or group coverage to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and provide the benefits or level of benefits needed for the medically necessary care and treatment of mental and nervous disorders, including substance use disorders. The bill also requires both individual and group policies to be provided in a manner no more restrictive than medical and surgical benefits, while nonquantitative treatment limitations cannot be applied more stringently than applicable restrictions in federal law.

The bill requires insurers to submit annual affidavits attesting to compliance with the MHPAEA, and it requires OIR to implement and enforce applicable provisions of the MHPAEA and federal guidance/regulations relating to the MHPAEA. The bill provides rulemaking authority to the

Financial Services Commission for implementation. The effective date of this section is January 1, 2021.

Section 10 repeals s. 627.669, F.S., relating to optional insurance coverage requirements for substance abuse impaired persons. The effective date of this section is January 1, 2021.

Section 11 amends s. 627.6699, F.S., making health benefits plans that provide coverage to employees of a small employer subject to s. 627.4193, F.S., to ensure compliance with the MHPAEA. The effective date of this section is January 1, 2021.

Section 12 amends s. 641.26, F.S., requiring HMOs that issue or deliver comprehensive major medical coverage to submit annual affidavits to OIR attesting to compliance with the newly created s. 627.4193, F.S., , to ensure compliance with the MHPAEA, and provides rulemaking authority for OIR to implement the requirement. The effective date of this section is January 1, 2021.

Section 13 amends s. 641.31, F.S., requiring all health maintenance contracts that provide comprehensive medical coverage to comply with the provisions of s. 627.4193, F.S., and provides rulemaking authority for OIR to implement the requirement. The effective date of this section is January 1, 2021.

Section 14 creates s. 786.1516, F.S., defining 'emergency care' to mean assistance or advice offered to avoid or attempt to mitigate a suicide emergency. The bill defines a 'suicide emergency' as an occurrence that reasonably indicates one is at risk of dying of or attempting suicide. The bill provides civil immunity for persons who provide emergency care at or near the scene of a suicide emergency.

Section 15 amends s. 1002.33, F.S., requiring all charter schools to incorporate 2 hours of suicide prevention training for all instructional personnel by October 1, 2020. The bill also requires all charter schools to have at least 2 school-based staff members certified or otherwise competent in the use of a suicide screening instrument and have a policy in place to utilize the instrument to gauge a student's suicide risk before initiating a Baker Act or requesting the initiation of a Baker Act. The bill requires each charter school to report their compliance with these provisions to DOE.

Section 16 amends s. 1012.583, F.S., putting in place the same requirements for public schools as those detailed in Section 15 for charter schools. The bill also eliminates the 'Suicide Prevention Certified School' designation in statute.

Section 17 amends s. 394.495, F.S., to correct cross-references related to child and adolescent mental health systems of care.

Section 18 amends s. 394.496, F.S., to correct cross-references related to service planning.

Section 19 amends s. 394.9085, F.S., to correct a cross-reference related to behavioral provider liability.

Section 20 amends s. 409.972, F.S., to correct a cross-reference related to mandatory and voluntary enrollment in Medicaid.

Section 21 amends s. 464.012, F.S., to correct a cross-reference related to licensure of advanced registered nurse practitioners, fees, and controlled substance prescribing.

Section 22 amends s. 744.2007, F.S., to correct a cross-reference related to powers and duties of public guardians.

Section 23 requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to perform a review of suicide prevention programs and efforts made by other states and make recommendations on their applicability to Florida. The bill also requires OPPAGA to submit a report containing findings and recommendations to the President of the Senate and the Speaker of the House of Representatives by January 1, 2021.

Section 24 provides an effective date for the bill of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There may be a fiscal impact on health care practitioners who may be required to pay for the new continuing education courses. Charter schools may be impacted by having to

train and/or hire new personnel to meet the suicide prevention training and staffing requirements under the bill. These impacts are indeterminate.

C. Government Sector Impact:

Public schools may be impacted by having to train and/or hire new personnel to meet the suicide prevention training and staffing requirements under the bill. This impact is not expected to be significant.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 14.2019, 14.20195, 334.044, 394.455, 394.4573, 394.463, 394.495, 394.496, 394.9085, 409.972, 464.012, 627.6675, 627.6699, 641.26, 641.31, 744.2007, 1002.33, and 1012.583 of the Florida Statutes.

This bill creates sections 456.0342, 627.4193, and 786.1516 of the Florida Statutes.

This bill repeals sections 627.668 and 627.669 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.