SB 1844 by **Latvala**; (Compare to H 0409) Alien Insurers

425232	D	S	L	RCS	BI, Hays	Delete everything after	02/02 06:06 PM
256156	AA	S		RCS	BI, Hays	Delete L.209:	02/02 06:06 PM

SB 1860 by **Negron**; (Compare to CS/H 0119) Motor Vehicle Personal Injury Protection Insurance

791184	A	S		WD	BI, Richter	Delete L.299 - 1509:	02/02 06:06 PM
224150	AA	S		WD	BI, Gaetz	Delete L.2222:	02/02 06:06 PM
578696	AA	S	L	WD	BI, Margolis	Delete L.1342:	02/02 06:06 PM
527256	A	S		RCS	BI, Richter	Delete L.518 - 541.	02/02 06:06 PM
104666	SA	S		WD	BI, Gaetz	Delete L.1265 - 1270:	02/02 06:06 PM
220258	A	S		WD	BI, Richter	Delete L.1270:	02/02 06:06 PM
760588	A	S	L	WD	BI, Gaetz	Delete L.1265 - 1270:	02/02 06:06 PM

SB 1862 by **Negron**; Public Records/Donor Identifying Information/Division of Insurance Fraud

SB 1620 by **Richter**; (Compare to CS/H 1101) Insurance

160704	A	S		RCS	BI, Richter	Delete L.211 - 245:	02/02 06:06 PM
929464	A	S		RCS	BI, Richter	btw L.245 - 246:	02/02 06:06 PM
604062	A	S		RCS	BI, Richter	Delete L.804 - 913.	02/02 06:06 PM
377322	A	S		WD	BI, Richter	Delete L.919:	02/02 06:06 PM
467786	A	S		RCS	BI, Richter	Delete L.994:	02/02 06:06 PM
464972	A	S		RCS	BI, Richter	Delete L.1006:	02/02 06:06 PM
227828	A	S	L	RCS	BI, Sobel	Delete L.951:	02/02 06:06 PM

SB 910 by **Hays (CO-INTRODUCERS) Bennett**; (Compare to CS/H 0365) Public Employees

708624	D	S		RCS	BI, Hays	Delete everything after	02/02 06:06 PM
935180	AA	S		RCS	BI, Hays	Delete L.22 - 23:	02/02 06:06 PM

SB 1428 by **Smith**; (Compare to CS/H 0941) Renewal of a Commercial Lines Insurance Policy

144930	A	S		RCS	BI, Smith	Delete L.15 - 20:	02/02 06:06 PM

SB 1814 by **Smith**; (Identical to H 4061) Uniform Home Grading Scale

SB 1626 by **Gaetz**; (Identical to H 1409) State Contracting

725782	D	S		RCS	BI, Gaetz	Delete everything after	02/02 06:18 PM
946392	AA	S		RCS	BI, Bennett	btw L.897 - 898:	02/02 06:18 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Thursday, February 2, 2012
TIME: 3:15 —5:15 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1844** Latvala (Compare H 409)	Alien Insurers; Revising a provision exempting alien insurers from the requirement to obtain a certificate of authority; specifying that an alien insurer is exempt from having to obtain a certificate of authority if such insurer engages only in specified activities relating to the delivery of insurance policies or annuity contracts to nonresident policyowners; providing that a life insurance policy and annuity contract may be issued by an insurer domiciled outside the United States under certain conditions; providing that an alien insurer issuing policies or contracts in this state is subject to part IX of ch. 626, F.S., relating to unfair insurance trade practices, etc. BI 02/02/2012 Fav/CS BC	Fav/CS Yeas 9 Nays 0
2	**SB 1860** Negron (Compare CS/H 119, H 523, S 254, Link S 1862)	Motor Vehicle Personal Injury Protection Insurance; Providing that certain entities exempt from licensure as a health care clinic must nonetheless be licensed in order to receive reimbursement for the provision of personal injury protection benefits; providing that knowingly submitting false, misleading, or fraudulent documents relating to licensure as a health care clinic, or submitting a claim for personal injury protection relating to clinic licensure documents, is a fraudulent insurance act under certain conditions; authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud, etc. BI 02/02/2012 Fav/CS BC	Fav/CS Yeas 9 Nays 0
3	**SB 1862** Negron (Link S 1860)	Public Records/Donor Identifying Information/Division of Insurance Fraud; Amending provisions as created by SB 1860; exempting from public record requirements all identifying information of a donor or prospective donor to the motor vehicle insurance fraud direct-support organization of the Division of Insurance Fraud, etc. BI 02/02/2012 Favorable GO	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1620** Richter (Compare CS/H 1101, CS/H 1223, CS/S 1122)	Insurance; Providing that a salvage motor vehicle dealer is not required to carry certain insurance on vehicles that have been issued a certificate of destruction; revising provisions specifying which insurers are not subject to certain filing requirements relating to reinsurance; providing that provisions relating to insurance adjusters do not apply to individuals who conduct data entry into an automated claims adjustment system for portable electronics insurance claims; revising provisions relating to the notice that an insurer must provide to an insured regarding the nonrenewal, cancellation, or termination of a commercial residential property insurance policy, etc. BI 02/02/2012 Fav/CS BC	Fav/CS Yeas 8 Nays 0
5	**SB 910** Hays (Similar H 365)	Public Employees; Revising conditions under which certain firefighters, law enforcement officers, correctional officers, or correctional probations officers who suffer or have died from any of specified medical conditions are presumed to have been injured or killed accidentally and in the line of duty; revising the conditions under which the presumption with respect to disability due to any of specified diseases is against occurrence in the line of duty for purposes of workers' compensation claims; providing medical conditions or behaviors that are appropriate for consideration in denying or overcoming the presumption of accidental disabilities or death suffered in the line of duty for firefighters and police officers, etc. BI 02/02/2012 Fav/CS GO BC	Fav/CS Yeas 7 Nays 1
6	**SB 1428** Smith (Compare CS/H 941)	Renewal of a Commercial Lines Insurance Policy; Providing that the transfer of a policy to certain other insurers is considered a renewal of the policy rather than a cancellation or nonrenewal, etc. BI 02/02/2012 Fav/CS BC	Fav/CS Yeas 8 Nays 0
7	**SB 1814** Smith (Identical H 4061, Compare S 1692)	Uniform Home Grading Scale; Repealing provisions relating to the required adoption by the Financial Services Commission of a uniform home grading scale to grade the ability of a home to withstand the wind load from certain tropical storms or hurricanes, etc. BI 02/02/2012 Favorable BC	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1626** Gaetz (Identical H 1409, Compare CS/H 5203)	State Contracting; Requiring agreements funded with state or federal financial assistance to include a performance measure for each deliverable, to be reviewed and approved in accordance with rules adopted by the Department of Financial Services, and to have the contracting entity assign a grants manager who is responsible for enforcing performance of the agreement; revising provisions relating to the Chief Financial Officer's intergovernmental contract tracking system under the Transparency Florida Act; dividing the responsibilities of the Department of Management Services under ch. 287, F.S., with the Department of Financial Services, etc. BI 02/02/2012 Fav/CS GO BC	Fav/CS Yeas 9 Nays 0

Other related meeting documents

425232

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
	.	
	.	
	.	

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 (8) of section 624.402, Florida Statutes, is amended, and subsection (9) is added to that section, to read:

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

(8)(a) An insurer domiciled outside the United States covering only persons who, at the time of issuance or renewal,

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are nonresidents of the United States if:

1. The insurer ~~or any affiliated person as defined in s. 624.04 under common ownership or control with the insurer~~ does not solicit, sell, or accept application for any insurance policy or contract to be delivered or issued for delivery to any person in any state;

2. The insurer registers with the office via a letter of notification upon commencing business from this state;

3. The insurer provides the following information, in English, to the office annually by March 1:

a. 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;

b. The lines of insurance and types of products offered by the insurer;

c. A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered for those lines of insurance and types of products in that domicile; and

d. A copy of the filings required by the applicable regulatory body of the insurer's country of domicile in that country's official language or in English, if available;

4. All certificates, policies, or contracts issued in this state showing coverage under the insurer's policy include the following statement in a contrasting color and at least 10-point

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type: "The policy providing your coverage and the insurer providing this policy have not been approved by the Florida Office of Insurance Regulation"; and

5. If ~~In the event~~ the insurer ceases to do business from this state, the insurer will provide written notification to the office within 30 days after cessation.

(b) For purposes of this subsection, "nonresident" means a trust or other entity organized and domiciled under the laws of a country other than the United States or a person who resides in and maintains a physical place of domicile in a country other than the United States, which he or she recognizes as and intends to maintain as his or her permanent home. A nonresident does not include an unauthorized immigrant present in the United States. Notwithstanding any other ~~provision of~~ law, it is conclusively presumed, for purposes of this subsection, that a person is a resident of the United States if the ~~such~~ person has:

1. Had his or her principal place of domicile in the United States for 180 days or more in the 365 days before ~~prior to~~ issuance or renewal of the policy;

2. Registered to vote in any state;

3. Made a statement of domicile in any state; or

4. Filed for homestead tax exemption on property in any state.

(c) Subject to the limitations provided in this subsection, services, including those listed in s. 624.10, may be provided by the insurer or an affiliated person as defined in s. 624.04 under common ownership or control with the insurer.

(d) An alien insurer transacting insurance in this state

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without complying with this subsection is ~~shall~~ be in violation of this chapter and subject to the penalties provided in s. 624.15.

(9)(a) Life insurance policies or annuity contracts may be solicited, sold, or issued in this state by an insurer domiciled outside the United States, covering only persons who, at the time of issuance are nonresidents of the United States, provided that:

1. The insurer is currently an authorized insurer in his or her country of domicile as to the kind or kinds of insurance proposed to be offered and must have been such an insurer for not fewer than the immediately preceding 3 years, or must be the wholly owned subsidiary of such authorized insurer or must be the wholly owned subsidiary of an already eligible authorized insurer as to the kind or kinds of insurance proposed for a period of not fewer than the immediately preceding 3 years. However, the office may waive the 3-year requirement if the insurer has operated successfully for a period of at least the immediately preceding year and has capital and surplus of not less than $25 million.

2. Before the office may grant eligibility, the requesting insurer furnishes the office with a duly authenticated copy of its current annual financial statement, in English, and with all monetary values therein expressed in United States dollars, at an exchange rate then-current and shown in the statement, in the case of statements originally made in the currencies of other countries, and with such additional information relative to the insurer as the office may request.

3. The insurer has and maintains surplus as to

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policyholders of not less than $15 million. Any such surplus as to policyholders shall be represented by investments consisting of eligible investments for like funds of like domestic insurers under part II of chapter 625; however, any such surplus as to policyholders may be represented by investments permitted by the domestic regulator of such alien insurance company if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like domestic insurers under part II of chapter 625.

4. The insurer has of good reputation as to providing service to its policyholders and the payment of losses and claims.

5. To maintain eligibility, the insurer furnishes the office within the time period specified in s. 624.424(1), a duly authenticated copy of its current annual and quarterly financial statements, in English, and with all monetary values therein expressed in United States dollars, at an exchange rate then-current and shown in the statement, in the case of statements originally made in the currencies of other countries, and with such additional information relative to the insurer as the office may request.

6. An insurer receiving eligibility under this subsection agrees to make its books and records pertaining to its operations in this state available for inspection during normal business hours upon request of the office.

7. The insurer notifies the applicant in clear and conspicuous language:

a. The date of organization of the insurer.

b. The identity of and rating assigned by each recognized

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insurance company rating organization that has rated the insurer or, if applicable, that the insurer is unrated.

c. That the insurer does not hold a certificate of authority issued in this state and that the office does not exercise regulatory oversight over the insurer.

d. The identity and address of the regulatory authority exercising oversight of the insurer. This paragraph does not impose upon the office any duty or responsibility to determine the actual financial condition or claims practices of any unauthorized insurer, and the status of eligibility, if granted by the office, indicates only that the insurer appears to be financially sound and to have satisfactory claims practices and that the office has no credible evidence to the contrary.

(b) If the office has reason to believe that an insurer issuing policies or contracts pursuant to this subsection is insolvent or is in unsound financial condition, does not make reasonable prompt payment of benefits, or is no longer eligible under the conditions specified in this subsection, the office may conduct an examination or investigation in accordance with s. 624.316, s. 624.3161, or s. 624.320 and, if the findings of the examination or investigation warrant, may withdraw the eligibility of the insurer to issue policies or contracts pursuant to this subsection without having a certificate of authority issued by the office.

(c) This subsection does not provide an exception to the agent licensure requirements of chapter 626. A insurer issuing policies or contracts pursuant to this subsection shall appoint the agents that the insurer uses to sell such policies or contracts as provided in chapter 626.

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(d) An insurer issuing policies or contracts pursuant to this subsection is subject to part IX of chapter 626, Unfair Insurance Trade Practices Act, and the office may take such actions against the insurer for a violation as are provided in that part.

(e) Policies and contracts issued pursuant to this subsection are not subject to the premium tax specified in s. 624.509.

(f) Applications for life insurance coverage offered under this subsection must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

> This policy is primarily governed by the laws of a foreign country. As a result, all of the rating and underwriting laws applicable to policies filed in this state do not apply to this coverage, which may result in your premiums being higher than would be permissible under a Florida-approved policy. A purchase of individual life insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual life policy. If the insurer issuing your policy becomes insolvent, this policy is not covered by the Florida Life and Health Insurance Guaranty Association. For information concerning individual life coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

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(g) All life insurance policies and annuity contracts issued pursuant to this subsection must contain on the first page of the policy or contract, in contrasting color and not less than 10-point type, the following statement:

The benefits of the policy providing your coverage are governed primarily by the law of a country other than the United States.

(h) All single-premium life insurance policies and single-premium annuity contracts issued to persons who are not residents of the United States and are not nonresidents illegally residing in the United States pursuant to this subsection are subject to chapter 896.

(i) For purposes of this subsection, the term "nonresident" means a trust or other entity or person as defined in subsection 624.402(8).

(j) An alien insurer transacting insurance in this state without complying with this subsection is in violation of this chapter and subject to the penalties provided in s. 624.15, and must also pay the fine required for each violation as prescribed by s. 626.10.

Section 2. This act shall take effect upon becoming a law.

========== 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:

425232

A bill to be entitled

An act relating to alien insurers; amending s. 624.402, F.S.; revising a provision exempting alien insurers from the requirement to obtain a certificate of authority; revising the definition of the term "nonresident"; providing that a life insurance policy and annuity contract may be issued by an insurer domiciled outside the United States under certain conditions; specifying the terms and conditions that must be satisfied before an alien insured may issue a policy or contract; authorizing the Office of Insurance Regulation to conduct an examination of an alien insurer if the office has reason to believe that the insurer is insolvent or is in unsound financial condition; providing that an alien insurer issuing policies or contracts in this state is subject to part IX of ch. 626, F.S., relating to unfair insurance trade practices; authorizing the office to enforce part IX of ch. 626, F.S.; providing that policies and contracts issued pursuant to the act are not subject to the premium tax; requiring that an application for a life insurance policy or an annuity contract contain certain specified statements to protect consumers; providing an effective date.

256156

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment to Amendment (425232)

Delete line 209
and insert:
by s. 626.910.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

_____
Meeting Date

Topic _____ Bill Number 184Y *(if applicable)*

Name Robert Reyes Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 108 S. Monroe St Phone 850 681 0024

Street

Tall Fl 32301 E-mail _____

City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing Trans America Life

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic _____ Bill Number SB1844 *(if applicable)*

Name Paul Sanford Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 106 S. Monroe St Phone 850-222-7200
Street
Tallahassee FL 32301 E-mail _____
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing FIC, ACLU

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic ALIENS

Bill Number 1844 *(if applicable)*

Name MONTE STEVENS

Amendment Barcode *(if applicable)*

Job Title DIR. GOVT AFFAIRS

Address 200 E. GAINES ST
Street
TALLAHASSEE FL 32301
City *State* *Zip*

Phone 413-2571

E-mail monte.stevens@flora.org

Speaking: ☑ For ☐ Against ☐ Information

Representing OIR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 1844

INTRODUCER: Banking and Insurance Committee and Senator Latvala

SUBJECT: Alien Insurers

DATE: February 3, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.			BC	
3.				
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 Office of Insurance Regulation regulates and licenses insurers and other risk-bearing entities.[1] Regulatory oversight includes licensure, approval of rates and policy forms, market conduct and financial exams, solvency oversight, and administrative supervision, as provided in the insurance code or ch. 636, F.S.[2]

In 2011, the Legislature created an exemption from the requirement to obtain a certificate of authority (COA) for any insurer domiciled outside the U.S. (alien insurer) and insuring only persons who, at the time of issuance or renewal, are nonresidents of the U.S., if the alien insurer met certain conditions. The law also provides that the alien insurer, or any affiliated person, may not solicit, sell, or accept application for any insurance policy or contract to be delivered or issued to any person in the U.S.[3] The bill revises the current exemption provisions relating to such alien insurers in the following manner:

[1] Risk-bearing entities include, but are not limited to multiple-employer welfare arrangements, commercial self-insurance funds, warranty associations, health maintenance organizations, prepaid limited health service organizations, prepaid health clinics, and continuing care facilities.

[2] Section 20.121(3)(a)2., F.S.

[3] s.4, Ch. 2011-174, L.O.F.

- Deletes the reference to affiliated persons from the prohibition on insurers soliciting or selling policies, or accepting applications for any person in the United States. Thus, an insurer who has an affiliate would not be disqualified from obtaining an exemption.
- Expands the definition of nonresident to include a trust or other entity organized and domiciled under the laws of a country other than the United States.

The bill also creates an exemption from the COA requirements for an alien insurer issuing life insurance or annuity contracts covering only persons who are not residents of the U.S., if the insurer meets the following requirements:

- The insurer is an authorized insurer in its domiciliary country in the kinds of insurance proposed to be offered in this state; and:
    - Has been an insurer for at least the last 3 consecutive years; or
    - Is the wholly owned subsidiary of an authorized insurer; or is the wholly owned subsidiary of an already eligible authorized insurer as to the kind of insurance proposed to be issued in this state for a period of not less than the immediately preceding 3 years.
- Prior to the OIR granting eligibility to an alien insurer to issue policies and contracts in Florida, the insurer is required to meet the following requirements:
    - Submit a copy of its annual financial statement to the OIR in English and with all monetary values expressed in U.S. dollars.
    - Maintain a surplus of at least $15 million in eligible investments for like funds of like domestic insurers or by investments permitted by the domiciliary regulator, if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of domestic insurers under part II of ch. 625, F.S.
    - Have a good reputation for providing service and paying claims.
    - Furnish to the OIR with annual and quarterly financial statements.
    - Provide certain disclosures to policy or contract applicants, such as the date the insurer was organized; the identity and rating assigned by each rating organization that has rated the insurer; the insurer does not hold a COA; the OIR does not exercise regulatory oversight over the insurer; the policy or contract is not covered by a guaranty association, and the identity and address of the regulatory authority exercising oversight of the insurer.

This bill substantially amends the following section of the Florida Statutes: 624.402.

II. Present Situation:

Regulation of Insurance in Florida

The Florida Insurance Code contains many provisions designed to prevent insurers from becoming insolvent and to protect and provide recovery for policyholders in the event of insolvency. These provisions include minimum capital and surplus requirements[4] and financial reporting requirements.[5] In addition, five guaranty funds are established under ch. 631, F.S., to

[4] Section 624.4095, F.S.
[5] Section 624.424, F.S.

ensure that policyholders of liquidated insurers are protected with respect to insurance premiums paid and settlement of outstanding covered claims, up to limits provided by law. Generally, entities subject to regulation under the insurance code are subject to assessments of the applicable guaranty association.

Section 624.401, F.S., requires insurers and other risk-bearing entities to obtain a certificate of authority from the OIR prior to engaging in insurance transactions unless specifically exempted. Section 624.402(8), F.S., provides an exemption from the requirement to obtain a COA for any insurer domiciled outside the U.S. and insuring only persons who, at the time of issuance or renewal, are nonresidents of the U.S.[6] A "nonresident" is defined as a person who resides in and maintains a physical place of domicile in a country other than the U.S., and intends to maintain such place of domicile as her or his permanent residence. For purposes of this subsection, a U.S. resident is a person who has:

- Had her or his principal place of domicile in the United States for 180 days or more in the 365 days prior to issuance or renewal of 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.

To be eligible for the exemption from the COA requirements, the insurer must:

- Not solicit, sell, or accept application for any insurance policy or contract for issue or delivery to U.S. residents. The prohibition also applies to any affiliated person of the insurer. Under current law, if a holding company wants to establish a Florida office for their alien affiliate, they are prohibited if the holding company owns another entity already licensed in Florida.
- Register with the OIR.
- Provide a disclosure on all certificates, contracts, and policies issued in Florida stating that the policy has not been approved by the OIR.
- Provide the following information to the OIR on an annual basis:
    - Name of the insurer and the country of domicile;
    - Names of the owners, officers, and directors and the number of employees;
    - Lines of insurance and types of products offered;
    - A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered in that domicile; and
    - A copy of filings required by the insurer's domicile.

III. Effect of Proposed Changes:

Section 1 revises the current exemption from the COA requirements for an insurer domiciled outside the U.S. covering nonresidents of the U.S. at the time of issuance or renewal. Under current law, the alien insurer, or any affiliated person, may not solicit, sell, or accept application for any insurance policy or contract to be delivered or issued to any person in the U.S. The bill makes the following changes:

[6] Ch. 2011-174, L.O.F.

- Only the alien insurer is prohibited from soliciting, selling, or accepting application for any policy or contract to be delivered or issued for delivery in the U.S. The affiliated person is removed from this restriction.
- The definition of nonresident is revised to include a trust or other entity organized and domiciled under the laws of a country other than the U.S.

New Exemption from the COA Requirements

The bill creates s. 624.402(9), F.S., which provides an exemption from the COA requirements for insurers domiciled outside the U.S. selling life and annuity coverage to persons in Florida who, at the time of issuance, are not U.S. residents if the following conditions are met:

- The insurer is an authorized insurer in its domiciliary country in the kinds of insurance proposed to be offered in this state; and:
    - Has been an insurer for at least the last 3 consecutive years; or
    - Is the wholly owned subsidiary of an authorized insurer; or is the wholly owned subsidiary of an already eligible authorized insurer as to the kind of insurance proposed to be issued in this state for a period of not less than the immediately preceding 3 years.

- Prior to the OIR granting an alien eligibility to issue policies and contracts in Florida, the insurer is required to meet the following requirements:
    - Submit a copy of its annual financial statement to the OIR in English and with all monetary values expressed in U.S. dollars.
    - Maintain a surplus of at least $15 million in eligible investments for like funds of like domestic insurers or by investments permitted by the domiciliary regulator, if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of domestic insurers under part II of ch. 625, F.S.
    - Have a good reputation for providing service and paying claims.
    - Furnish the OIR with annual and quarterly financial statements.
    - Allow access to the insurer's books and records pertaining to its operations in Florida, at the request of the OIR.
    - Provide certain disclosures to policy or contract applicants, such as the identity and rating assigned by each rating organization that has rated the insurer. Also the insurer must disclose that the OIR does not exercise regulatory oversight over the insurer; the policy or contract is not covered by a guaranty association, and the identity and address of the regulatory authority exercising oversight of the insurer.

The OIR may waive the 3-year operating requirement if the insurer has "operated successfully" for at least one year prior and has a surplus of at least $25 million. The bill also provides that these provisions do not impose upon the OIR any duty or responsibility to determine the actual financial condition or claims practices of an unauthorized insurer, and the status of eligibility, if granted, indicates only that the insurer appears to be financially sound and that the OIR has no credible evidence to the contrary. The bill provides that if the OIR has reason to believe that such an insurer is insolvent or is in unsound financial condition, or is no longer eligible to issue

policies or contracts subject to the conditions of this subsection, the OIR may conduct an investigation or examination and may withdraw eligibility of the insurer.

The definition of nonresident is provided by a cross-reference to s. 624.402(8), F.S.

Eligible insurers issuing policies or contracts pursuant to this subsection are subject to part IX of ch. 626, F.S., and the OIR may take action against such insurers for violations of the Unfair Trade Practices Act. Insurers violating provisions of this new subsection are also subject to the penalties provided in ss. 624.15 and 626.910, F.S.

All single-premium life insurance policies and single-premium annuity contracts issued to persons who are not residents of the United States and are not nonresidents illegally residing in the United States are subject to ch. 896, F.S., Offenses Related to Financial Transactions.

This subsection does not create an exception to the agent licensure requirements of ch. 626, F.S. An insurer issuing policies or contracts are required to appoint the agents the insurer uses to sell such policies or contracts as provided in ch. 626, F.S.

Policies and contracts issued pursuant to this subsection are not subject to the premium tax specified in s. 624.509, F.S.

Section 2 provides that this act 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.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

By expanding the exemptions from the COA requirements to insurers domiciled outside of the U.S., and selling life insurance policies and annuity contracts to nonresidents of the U.S., the bill will allow for an increase in the lines and types of insurance offerings. The

bill will reduce the regulatory burden for these insurers while preserving regulatory oversight on insurers selling policies and contracts to U.S. residents. Nonresidents could benefit from such coverage.

The definition of "nonresident" is expanded under s. 624.402(8), F.S., to include a trust or other entity organized and domiciled under the laws of a country other than the United States. This will allow life insurance trusts and other entities to obtain coverage under these non-regulated policies.

C. Government Sector Impact:

Prior to the repeal of the existing exemption from the COA requirements for alien insurers selling life insurance and annuity contracts to nonresidents in 2011,[7] the OIR reported that there were three insurers that had met the eligibility requirements for an exemption. This number had not changed in recent years.

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 Banking and Insurance on February 2, 2012:

The CS provides the following changes:

- Provides that an alien insurer issuing life insurance policies or annuity contracts in Florida is subject to the fines prescribed in s. 626.910, F.S., if the insurer fails to comply with the provisions of s. 624.402(9), F.S.
- Reinstates the prohibition on renewing policies to residents as a requirement for alien insurers subject to the provisions of s. 624.402(8), F.S.
- Revises the effective date of the bill.
- Provides technical and conforming changes.

B. Amendments:

None.

[7] Ch. 2011-174, L.O.F.

By Senator Latvala

16-00583A-12 20121844__

A bill to be entitled

An act relating to alien insurers; amending s. 624.402, F.S.; revising a provision exempting alien insurers from the requirement to obtain a certificate of authority; providing an exception for the issuance of life insurance policies and annuity contracts; specifying that an alien insurer is exempt from having to obtain a certificate of authority if such insurer engages only in specified activities relating to the delivery of insurance policies or annuity contracts to nonresident policyowners; revising the definition of the term "nonresident"; providing that a life insurance policy and annuity contract may be issued by an insurer domiciled outside the United States under certain conditions; specifying the terms and conditions that must be satisfied before an alien insured may issue a policy or contract; authorizing the Office of Insurance Regulation to conduct an examination of an alien insurer if the office has reason to believe that the insurer is insolvent or is in unsound financial condition; providing that an alien insurer issuing policies or contracts in this state is subject to part IX of ch. 626, F.S., relating to unfair insurance trade practices; authorizing the office to enforce part IX of ch. 626, F.S.; providing that policies and contracts issued pursuant to the act are not subject to the premium tax; requiring that an application for a life insurance policy or an annuity contract contain certain specified statements to

16-00583A-12 20121844__

protect consumers; providing an effective date.

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

Section 1. Subsection (8) of section 624.402, Florida Statutes, is amended, and subsection (9) is added to that section, to read:

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

(8)(a) Except as otherwise provided in subsection (9) with respect to life insurance policies or annuity contracts, issuance of other policies or contracts by an insurer domiciled outside the United States covering only persons who, at the time of issuance ~~or renewal~~, are nonresidents of the United States if:

1. The insurer does not solicit, sell, or accept application for such insurance policy or annuity contract ~~or any affiliated person as defined in s. 624.04 under common ownership or control with the insurer does not solicit, sell, or accept application for any insurance policy or contract~~ to be delivered or issued for delivery to any person in any state;

2. The insurer registers with the Office of Insurance Regulation via a letter of notification upon commencing business from this state;

3. The insurer provides the following information, in English, to the Office of Insurance Regulation annually by March 1:

a. 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;

b. The lines of insurance and types of products offered by the insurer other than life insurance policies or annuity contracts;

c. A statement from the applicable regulatory body of the insurer's domicile certifying that the insurer is licensed or registered for those lines of insurance and types of products in that domicile; and

d. A copy of the filings required by the applicable regulatory body of the insurer's country of domicile in that country's official language or in English, if available;

4. All certificates, policies, or contracts 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

5. In the event the insurer ceases to do business from this state, the insurer will provide written notification to the office within 30 days after cessation.

(b) For purposes of this subsection and subsection (9), the term "nonresident" means a trust or other entity organized and domiciled under the laws of a country other than the United States or a person who resides in and maintains a physical place

of domicile in a country other than the United States, which he or she recognizes as and intends to maintain as his or her permanent home. A nonresident does not include an unauthorized immigrant present in the United States. Notwithstanding any other ~~provision of~~ law, it is conclusively presumed, for purposes of this subsection, that a person is a resident of the United States if the ~~such~~ person has:

1. Had his or her principal place of domicile in the United States for 180 days or more in the 365 days before ~~prior to~~ issuance or renewal of the policy;

2. Registered to vote in any state;

3. Made a statement of domicile in any state; or

4. Filed for homestead tax exemption on property in any state.

(c) Subject to the limitations provided in this subsection, services, including those listed in s. 624.10, may be provided by the insurer or an affiliated person as defined in s. 624.04 under common ownership or control with the insurer.

(d) An alien insurer transacting insurance in this state without complying with this subsection or subsection (9) is ~~shall be~~ in violation of this chapter and subject to the penalties provided in s. 624.15.

(9)(a) A life insurance policy or annuity contract issued by an insurer domiciled outside the United States covering only persons who, at the time of issuance, are not residents of the United States, if:

1. The insurer is currently an authorized insurer in its country of domicile as to the kind of insurance proposed to be offered here and:

a. Has been an insurer for not less than the immediately preceding 3 years;

b. Is the wholly owned subsidiary of an authorized insurer; or

c. Is the wholly owned subsidiary of an already eligible authorized insurer as to the kind of insurance proposed to be issued in this state for a period of not less than the immediately preceding 3 years.

The Office of Insurance Regulation may waive the 3-year requirement if the insurer has operated successfully for a period of at least the immediately preceding year and has capital and surplus of not less than $25 million.

2. Before the Office of Insurance Regulation grants the insurer eligibility to issue policies or contracts in this state, the requesting insurer furnishes the office with a duly authenticated copy of its current annual financial statement, in English, and with all monetary values therein expressed in United States dollars, at an exchange rate then-current and shown in the statement, in the case of statements originally made in the currencies of other countries, and with such additional information as the office may request.

3. The insurer has and maintains surplus as to its policyholders of not less than $15 million. Any surplus in favor of policyholders shall be represented by investments consisting of eligible investments for like funds of like domestic insurers under part II of chapter 625. However, any surplus in favor to policyholders may be represented by investments permitted by the domestic regulator of such alien insurance company if the

investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like domestic insurers under part II of chapter 625.

4. The insurer has a good reputation for providing service to its policyholders and the payment of losses and claims.

5. The insurer furnishes the Office of Insurance Regulation within the time period specified in s. 624.424(1) a duly authenticated copy of its current annual and quarterly financial statements, in English, and with all monetary values therein expressed in United States dollars, at an exchange rate then-current and shown in the statement, in the case of statements originally made in the currencies of other countries, and with such additional information relative to the insurer as the office may request.

6. The insurer agrees to make its books and records pertaining to its operations in this state available for inspection during normal business hours at the request of the office.

7. The insurer agrees to notify the applicant for a policy or contract in clear and conspicuous language:

a. The date the insurer was organized.

b. The identity of and rating assigned by each recognized insurance company rating organization that has rated the insurer or, if applicable, whether the insurer is unrated.

c. That the insurer does not hold a certificate of authority issued in this state and that the Office of Insurance Regulation does not exercise regulatory oversight over the insurer.

d. The identity and address of the regulatory authority

exercising oversight of the insurer.

This paragraph does not impose upon the Office of Insurance Regulation any duty or responsibility to determine the actual financial condition or claims practices of an unauthorized insurer, and the status of eligibility, if granted by the office, indicates only that the insurer appears to be financially sound and to have satisfactory claims practices and that the office has no credible evidence to the contrary.

(b) If at any time the Office of Insurance Regulation has reason to believe that an insurer issuing policies or contracts pursuant to this subsection is insolvent or is in unsound financial condition, does not make reasonable prompt payment of benefits, or is no longer eligible to issue policies or contracts under the conditions specified in this subsection, the office may conduct an examination or investigation in accordance with s. 624.316, s. 624.3161, or s. 624.320 and, if the findings of the examination or investigation warrant, may withdraw the eligibility of the insurer to issue policies or contracts pursuant to this subsection without having a certificate of authority issued by the office.

(c) This subsection does not provide an exception to the agent licensure requirements of chapter 626. An insurer issuing policies or contracts pursuant to this subsection shall appoint the agents that the insurer uses to sell such policies or contracts as provided in chapter 626.

(d) An insurer issuing policies or contracts pursuant to this subsection is subject to part IX of chapter 626, relating to unfair insurance trade practices, and the office may take

such action against the insurer for a violation as are provided in that part.

(e) Policies and contracts issued pursuant to this subsection are not subject to the premium tax specified in s. 624.509.

(f) An application for life insurance coverage or an annuity contract offered under this subsection must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

> This policy is primarily governed by the laws of a foreign country. As a result, all of the rating and underwriting laws applicable to policies filed in this state do not apply to this coverage, which may result in your premiums being higher than would be permissible under a Florida-approved policy. Any purchase of individual life insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual life policy. If the insurer issuing your policy becomes insolvent, this policy is not covered by the Florida Life and Health Insurance Guaranty Association. For information concerning individual life coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

(g) All life insurance policies and annuity contracts issued pursuant to this subsection must contain on the first

page of the policy or contract, in contrasting color and not less than 10-point type, the following statement:

The benefits of the policy providing your coverage are governed primarily by the law of a country other than the United States.

(h) All single-premium life insurance policies and single-premium annuity contracts issued to persons who are not residents of the United States and are not nonresidents illegally residing in the United States pursuant to this subsection are subject to chapter 896.

Section 2. This act shall take effect July 1, 2012.

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
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	.	

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

Senate Amendment (with title amendment)

Delete lines 299 - 1509
and insert:
Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, unless exempted under s. 627.736(5)(h), or under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law, unless exempted under s. 627.7485(1)(a)2.

Section 3. Subsection (6) is added to section 400.991, Florida Statutes, to read:

400.991 License requirements; background screenings; prohibitions.—

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

INSURANCE FRAUD NOTICE.—A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault Emergency Care Coverage Law, commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for personal injury protection or emergency care coverage benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in s. 817.234, Florida Statutes.

Section 4. Subsection (1) of section 626.989, Florida Statutes, is amended to read:

626.989 Investigation by department or Division of Insurance Fraud; compliance; immunity; confidential information; reports to division; division investigator's power of arrest.—


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

(a) A person commits a "fraudulent insurance act" if the person:

1. Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto.

2. Knowingly submits:

a. A false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400 with an intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault Emergency Care Coverage Law.

b. A claim for payment or other benefit pursuant to an insurance policy under the Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault Emergency Care Coverage Law if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when


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applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400. ~~For the purposes of this section,~~

(b) The term "insurer" also includes a ~~any~~ health maintenance organization, and the term "insurance policy" also includes a health maintenance organization subscriber contract.

Section 5. Section 626.9895, Florida Statutes, is created to read:

626.9895 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 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; raise funds; request and receive grants, gifts, and


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bequests of money; acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and 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 used exclusively to advance the prosecution, investigation, or prevention of motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of 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.

(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


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the organization by the division.

(b) Submission of an annual budget for 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, if appropriate.

(c) Certification by the division that the 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 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.—

(a) The board of directors of the organization shall consist of the following eleven members:

1. The Chief Financial Officer, or designee, who shall serve as chair.

2. 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.

3. Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.

4. 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.

5. Two representatives of the types of health care providers who regularly make claims for benefits under the Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault Emergency Care Coverage Law, one of whom shall be appointed by the President of the Senate and one of whom shall be appointed by the Speaker of the House of Representatives. The appointees may not represent the same type of health care provider.

6. A private attorney who has experience in representing claimants in actions for benefits under the Florida Motor Vehicle No-Fault Law, who shall be appointed by the President of the Senate.

7. A private attorney who has experience in representing insurers in actions for benefits under the Florida Motor Vehicle No-Fault Law, who shall be appointed by the Speaker of the House


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of Representatives.

(b) 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 FROM INSURERS.—Contributions from an insurer to the organization shall be allowed as an appropriate business expense of the insurer for all regulatory purposes.

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

(8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by


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the division from the organization shall be deposited into the Insurance Regulatory Trust Fund.

Section 6. Subsection (12) of section 627.0651, Florida Statutes, is amended to read:

627.0651 Making and use of rates for motor vehicle insurance.—

(12)(a) Any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may ~~shall~~ not be included in the insurer's rate base~~,~~ and ~~shall not be~~ used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may ~~shall~~ not be used to justify a rate or rate change. The portion of the taxable costs and attorney ~~attorney's~~ fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may ~~shall~~ not be included in the insurer's rate base and used ~~shall not be utilized~~ to justify a rate or rate change.

(b) Any portion of a judgment or settlement for taxable costs and attorney fees in favor of a prevailing plaintiff against an insurer in a claim for benefits under the Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault Emergency Care Coverage Law may not be included in the insurer's rate base and used to justify a rate or rate change.

Section 6. Subsection (6) is added to section 627.733, Florida Statutes, to read:

627.733 Required security.—


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(6) The owner or registrant of a motor vehicle otherwise subject to this section is not required to maintain the security described herein if the owner or registrant maintains the security required under s. 627.7483.

Section 7. Subsections (1), (4), (5), (8), (9), (10), (11), and (16) of section 627.736, Florida Statutes, are amended to read:

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

(1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy providing personal injury protection must ~~complying with the security requirements of s. 627.733 shall~~ provide personal injury protection benefits to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the ~~such~~ motor vehicle, and other persons struck by the ~~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)(e), 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 for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices~~,~~ and medically necessary ambulance, hospital, and nursing services. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102. ~~However,~~ The medical benefits ~~shall~~ provide reimbursement only for ~~such~~ services and care that are lawfully provided,


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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:

a. A health care clinic 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


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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.

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


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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 shall give priority to the payment of death benefits over the payment of other benefits of the deceased and, upon learning of the death of the individual, shall stop paying the other benefits until the death benefits are paid. The insurer may pay death ~~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 to such benefits ~~thereto~~.

~~Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such 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. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of~~


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~~insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.~~

(4) PAYMENT OF BENEFITS~~; WHEN DUE~~.~~—~~Except for emergency care coverage under ss. 627.748-627.7491, personal injury protection benefits due from an insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except that benefits received under any workers' compensation law must ~~shall~~ be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under 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 under ss. 627.730-627.7405 are ~~shall be~~ subject to the provisions of the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to 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 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. However:


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1. If ~~such~~ written notice of the entire claim 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.

2. 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 if~~, provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must also ~~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.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification or explanation of benefits of the specified error. Upon receiving the specification or explanation, the person making the claim has, at the person's option and without waiving any other legal remedy for payment, 15 days to submit a revised claim. The revised claim shall be considered a timely submission of written notice of a claim.


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4. ~~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.

5. 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 that ~~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.

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (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.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of coverage ~~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


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30-day period, any amount of the reserve for which the insurer has not received notice of such claims ~~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 amount ~~personal injury protection benefits~~ not held in reserve is ~~are~~ insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(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. Interest is ~~shall be~~ due at the time payment of the overdue claim is made.

(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 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 for ~~with respect to~~ which personal injury protection benefits have been obtained pursuant to ~~security is required under~~ 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.

(f) If two or more insurers are liable for paying ~~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 the ~~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.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section


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with such frequency as to constitute a general business practice.

(h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the behalf of an insured person if that person has 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 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 in its entirety from the person who committed insurance fraud ~~in their entirety~~. The prevailing party is entitled to its costs and attorney ~~attorney's~~ fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. The insurer shall provide to the insured, or an assignee of the insured, a copy of the log within 30 days after receiving a request for the log from the insured or the assignee.

(j) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after

the limits have been reached.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)~~1.~~ A ~~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 a charge may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. In determining ~~With respect to a determination of~~ whether a charge for a particular service, treatment, or supply ~~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 motor vehicle ~~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 may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers


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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:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.


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However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, 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 is ~~was~~ rendered and for the area in which such services, supplies, or care is ~~were~~ rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable ~~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 license, regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or


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limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

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.

5. Effective January 1, 2013, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(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


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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 paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled 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

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 covered by personal injury protection benefits under this section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~


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~~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 ~~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 an ~~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 and care 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 that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring


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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 federal Centers for Medicare and Medicaid Services ~~Health Care Finance~~


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~~Administration~~.

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

BILLING REQUIREMENTS.—Florida law provides ~~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 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 a ~~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 the ~~Healthcare Correct Procedural Coding System (~~HCPCS~~)~~. All providers, other than hospitals, must ~~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 properly completed in their entirety as to all material provisions, with all relevant information being provided therein.


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(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;

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;

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,


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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. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The ~~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 "countersign" or "countersignature" ~~"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.

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 ~~that~~ is consistent with the services being rendered to the patient as claimed. The requirement to maintain ~~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 a ~~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.

(h) As provided in s. 400.9905, an entity excluded from the


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definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician if such entity has filed for a licensing exemption with the Agency for Health Care Administration;

4. A hospital or ambulatory surgical center licensed under chapter 395; or

5. An entity wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY ~~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 assignee of an insured's rights and the insurer, the provisions of ss. ~~s.~~ 627.428 and 768.79 ~~shall~~ apply, except as provided in subsections (10) and (15).

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract ~~enter into contracts~~ with preferred ~~licensed health care~~ providers for the benefits described in this section, including ~~referred to in this section as "preferred providers,"~~


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~~which shall include~~ health care providers licensed under chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing ~~purchase of~~ the policy ~~for personal injury protection benefits~~, if the requirements of this subsection are met. 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. If the insured elects to use a provider who is a preferred provider, 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. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. 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 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.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, ~~the insurer must be provided with~~ written notice of an intent to initiate litigation must be provided to the insurer. 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).

(b) The notice must ~~required shall~~ state that it is a


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"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 (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


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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 are ~~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 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 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


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obligated to pay any attorney ~~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) 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.~~

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) ~~If~~ An insurer ~~fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, the insurer~~ is engaging in a prohibited unfair or deceptive practice ~~that is~~ subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice: ~~with respect thereto~~

1. Fails to pay valid claims for personal injury protection; or

2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(16) SECURE ELECTRONIC DATA TRANSFER.—~~If all parties~~


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~~mutually and expressly agree,~~ A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Section 8. Section 627.748, Florida Statutes, is created to read:

627.748 Short title.—Sections 627.748-627.7491 may be cited as the "Florida Motor Vehicle No-Fault Emergency Care Coverage Law."

Section 9. Section 627.7481, Florida Statutes, is created to read:

627.7481 Purposes.—The purpose of the Florida Motor Vehicle No-Fault Emergency Care Coverage Law is to provide for emergency services and care, services and care provided in a hospital, prescribed follow-up care, funeral costs, and disability insurance benefits without regard to fault; to require motor vehicle insurance that secures such benefits for motor vehicles required to be registered in this state; and, with respect to motor vehicle accidents, to provide a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience.

Section 10. Section 627.74811, Florida Statutes, is created to read:

627.74811 Effect of law on emergency care coverage policies.—The provisions, schedules, and procedures authorized in ss. 627.748-627.7491 must be implemented by insurers offering policies pursuant to the Florida Motor Vehicle No-Fault


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Emergency Care Coverage Law. The Legislature intends that these provisions, schedules, and procedures have full force and effect regardless of their express inclusion in an insurance policy form and govern over any general provisions in the insurance policy form. An insurer is not required to amend its policy form or to expressly notify providers, claimants, or insureds of the applicable fee schedules in order to implement and apply such provisions, schedules, or procedures.

Section 11. Section 627.7482, Florida Statutes, is created to read:

627.7482 Definitions.—As used in ss. 627.748-627.7491, the term:

(1) "Broker" means any person not licensed under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for the use of medical equipment and is not the 100 percent owner or the 100 percent lessee of such equipment. For purposes of this subsection, 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.

(a) The term "broker" does not include:

1. A hospital or physician management company whose medical equipment is ancillary to the practices managed; a debt collection agency; an entity that has contracted with the insurer to obtain a discounted rate; 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


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100 percent owned by one or more hospitals or physicians.

2. A person or entity that certifies, upon the request of an insurer, that:

a. It is a clinic licensed under part X of chapter 400;

b. It is a 100 percent owner of medical equipment; and

c. The owner's only part-time lease of medical equipment for emergency care coverage patients is on a temporary basis not to exceed 30 days in a 12-month period and is necessitated by:

(I) The repair or maintenance of existing 100 percent-owned medical equipment;

(II) The pending arrival and installation of newly purchased medical equipment or the replacement 100-percent-owned medical equipment; or

(III) A determination by the medical director or clinical director that open-style medical equipment is medically necessary for the performance of tests or procedures for patients due to the patients' physical sizes or claustrophobia. The leased medical equipment may not be used, for medical treatment or services, for a patient who is not a patient of the registered clinic for medical treatment of services.

However, the 30-day lease period provided in this sub-subparagraph 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.

(b) As used in this subsection, the term "lessee" means a long-term lessee under a capital or operating lease but does not include a part-time lessee.


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(c) Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234.

(2) "Certify" means to swear or attest to a fact being true or accurately represented in a writing.

(3) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time for a safe transfer to another hospital before delivery;

2. That a transfer may pose a threat to the health and safety of the woman or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(4) "Emergency services and care" means medical screening, examination and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.


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

(6) "Knowingly" means having actual knowledge of information and acting in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the information. Proof of specific intent to defraud is not required.

(7) "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.

(8) "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.

(9) "Motor vehicle" means any self-propelled vehicle that has four or more wheels and 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. The term includes:

(a) A "private passenger motor vehicle," which is any motor vehicle that is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or

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business purposes, a motor vehicle of the pickup truck, panel truck, van, camper, or motor home type.

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

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

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

(11) "Owner," with respect to a motor vehicle, means a person who holds legal title to the motor vehicle or, if the motor vehicle is the subject of a security agreement or lease with an option to purchase and the debtor or lessee has the right to possession, the debtor or lessee of the motor vehicle.

(12) "Physician" means an allopathic physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459.

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

(14) "Relative residing in the insured's household" means a


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relative of any degree by blood, marriage, or adoption who usually makes her or his home in the same family unit regardless of whether she or he is temporarily living elsewhere.

(15) "Unbundling" means separating treatment or services that would be properly billed under one billing code into two or more billing codes, resulting in a payment amount greater than would be paid using one billing code.

(16) "Upcoding" means using a billing code to describe treatment or services in a manner that would result in a payment amount greater than would be paid using a billing code that accurately describes such treatment or services. 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.

Section 12. Section 627.7483, Florida Statutes, is created to read:

627.7483 Required security.—

(1) An owner or registrant of a motor vehicle, other than a motor vehicle used as a school bus as defined in s. 1006.25, a limousine, or a taxicab, which must be registered and licensed in this state shall continuously maintain security as described in subsection (3) throughout the licensing or registration period. An owner or registrant of a motor vehicle used as a taxicab shall maintain security as required under s. 324.032(1) and is exempt from s. 627.7486.

(2) A nonresident owner or registrant of a motor vehicle,


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whether operated or not operated, which has been physically present within this state for more than 90 days during the preceding 365 days must thereafter continuously maintain security as described in subsection (3) while such motor vehicle is physically present within this state.

(3) Security required by this section shall be provided:

(a) By an insurance policy delivered or issued for delivery in this state by an authorized or eligible motor vehicle liability insurer which provides the benefits and exemptions contained in ss. 627.748-627.7491. Any policy of insurance represented or sold as providing the security required under this section shall be deemed to provide insurance for the payment of the required benefits; or

(b) By any other method authorized by s. 324.031(2), (3), or (4) and approved by the Department of Highway Safety and Motor Vehicles as affording security equivalent to that afforded by a policy of insurance or by self-insuring as authorized by s. 768.28(16). The person filing such security has all of the obligations and rights of an insurer under ss. 627.748-627.7491.

(4) An owner of a motor vehicle for which security is required by this section who fails to have such security in effect at the time of an accident is not immune from tort liability and is personally liable for the payment of benefits under s. 627.7485. With respect to such benefits, the owner has all of the rights and obligations of an insurer under ss. 627.748-627.7491.

(5) In addition to persons who are not required to provide security under this section or s. 324.022, the owner or registrant of a motor vehicle who is a member of the United


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States Armed Forces and who is called to or on active duty outside the United States in an emergency situation is exempt from such requirements. The exemption applies only while the owner or registrant is on such active duty and while the motor vehicle otherwise required to be covered by the security under this section or s. 324.022 is not operated by any person. Upon receipt of a written request from the insured to whom this exemption applies, the insurer shall cancel the coverages and return any unearned premium or suspend the security required by this section and s. 324.022. Notwithstanding s. 324.0221(2), the Department of Highway Safety and Motor Vehicles may not suspend the registration or operator's license of the owner or registrant of a motor vehicle during the time she or he qualifies for this exemption. The owner or registrant of the motor vehicle qualifying for the exemption must immediately notify the department before and at the end of the expiration of the exemption.

Section 13. Section 627.7484, Florida Statutes, is created to read:

627.7484 Proof of security; security requirements; penalties.—

(1) The provisions of chapter 324 which pertain to the method of giving and maintaining proof of financial responsibility and which govern and define a motor vehicle liability policy apply to filing and maintaining proof of security required by ss. 627.748-627.7491.

(2) Any person who:

(a) Gives information required in a report or otherwise as provided in ss. 627.748-627.7491, knowing or having reason to


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believe that such information is false;

(b) Forges or, without authority, signs any evidence of proof of security; or

(c) Files, or offers for filing, any such evidence of proof, knowing or having reason to believe that it is forged or signed without authority

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 14. Section 627.7485, Florida Statutes, is created to read:

627.7485 Required emergency care coverage benefits.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.7483 must provide emergency care coverage to the named insured, relatives residing in the insured's household, persons operating the insured motor vehicle, passengers in the 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 subsection (2) and paragraph (4)(b), up 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 the motor vehicle as follows:

(a) *Medical benefits.*—

1. Eighty percent of all reasonable expenses for:

a. Emergency transport and treatment rendered by an ambulance provider licensed under part III of chapter 401 within 24 hours after the motor vehicle accident.

b. Emergency services and care rendered by a dentist,


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provided within 7 days after the motor vehicle accident if such services and care are provided:

(I) In a hospital or in a facility wholly owned by a hospital;

(II) In a facility wholly owned by a physician, or by the physician and the spouse, parents, children, or siblings of such physician; or

(III) In a facility wholly owned by a dentist, or by the dentist and the spouse, parents, children, or siblings of such dentist.

c. Services and care rendered when an insured is admitted to a hospital within 7 days after the motor vehicle accident, for a condition related to the motor vehicle accident.

d. If the insured receives emergency transport and treatment or emergency services and care pursuant to sub-sub-subparagraph a. or sub-subparagraph b., or services and care pursuant to sub-subparagraph c., prescribed follow-up services and care directly related to the medical diagnosis arising from the motor vehicle accident if:

(I) The diagnosis is rendered by a physician; and

(II) The prescribed follow-up services and care are rendered by a physician, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, an advanced registered nurse practitioner licensed under chapter 464, or a chiropractic physician licensed under chapter 460.

2. Prescribed follow-up services and care must be provided in a clinic licensed under part X of chapter 400 or an entity excluded from the definition of a clinic. However, as provided in s. 400.9905, an entity excluded from the definition of a


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clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement for prescribed follow-up services and care under sub-subparagraph 1.d. unless the entity is:

a. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

b. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

c. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician if such entity has filed for a licensing exemption with the Agency for Health Care Administration;

d. A hospital or ambulatory surgical center licensed under chapter 395; or

e. An entity wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395.

3. Reimbursement for services provided by a chiropractic physician is limited to the lesser of 24 treatments or to services rendered within 12 weeks after the date of the initial chiropractic treatment, whichever comes first, unless the insurer authorizes additional chiropractic services.

4. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102.

5. For purposes of ss. 627.748-627.7491, a medical diagnosis that an emergency medical condition exists is presumed to be correct unless rebutted by clear and convincing evidence

to the contrary.

(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 her or his household. All disability benefits payable under this paragraph must be paid at least every 2 weeks.

(c) *Death benefits.*—Death benefits equal to the lesser of $5,000 or the remainder of unused emergency care coverage insurance benefits per individual. The insurer shall give priority to the payment of death benefits over the payment of other benefits of the deceased and, upon learning of the death of the individual, shall stop paying the other benefits until the death benefits are paid. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person who appears to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the benefits required by this section, and such insurer may not 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 benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be

purchased in conjunction with emergency care coverage insurance. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.—An insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the insured's household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person if such person's conduct contributed to her or his injury under the following circumstance:

1. Causing injury to herself or himself intentionally; or

2. Being injured while committing a felony.

If an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(f) shall be held in abeyance, and the insurer shall withhold payment of any benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the

insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—An insurer may not have a lien on any recovery in tort by judgment, settlement, or otherwise for emergency care coverage benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under ss. 627.748-627.7491, or her or his legal representative, may not recover any damages for which benefits are paid or payable. The plaintiff may prove all of her or his special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, may not award damages for emergency care coverage benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff may not recover such special damages for emergency care coverage benefits paid or payable.

(4) PAYMENT OF BENEFITS.—

(a) Benefits due from an insurer under ss. 627.748-627.7491 are primary, except that benefits received under any workers' compensation law must be credited against the benefits provided under subsection (1) and are due and payable as loss accrues upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred that are covered by the policy issued under ss. 627.748-627.7491. If 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 under ss.


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627.748-627.7491 are subject to the provisions of the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer must repay the full amount of the benefits to the Medicaid program.

(b) The insurer of the owner of a motor vehicle shall pay benefits for an emergency medical condition as described in paragraph (1)(a) for accidental bodily injury requiring medical treatment:

1. 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. Sustained outside this state, but within the United States or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Sustained by a relative of the owner residing in the owner's household, under the circumstances described in subparagraph 1. or subparagraph 2. if the relative at the time of the accident is domiciled in the owner's household and is not the owner of a motor vehicle with respect to which security is required under ss. 627.748-627.7491.

4. 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 the injured person is not:

a. The owner of a motor vehicle for which security is required under ss. 627.748-627.7491; or

b. Entitled to benefits from the insurer of the owner of


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such motor vehicle.

(c) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle for which the policy provides the security required by ss. 627.748-627.7491.

(d) Upon receiving notice of an accident that is potentially covered by benefits under this section, the insurer must reserve $5,000 of such coverage for payment of medical benefits provided by physicians or dentists pursuant to subparagraph (1)(a). The reserved amount may be used only to pay claims for such providers 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 a claim for emergency care coverage benefits may be used to pay other claims. The time periods specified in paragraph (f) for the payment of benefits shall be tolled for the period of time that the insurer is required by this paragraph to hold payment of such other claims to the extent that the amount not held in reserve is insufficient to pay such other claims. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(e) An insurer shall create and maintain for each insured a log of benefits paid by the insurer on behalf of the insured. The insurer shall provide to the insured, or an assignee of the insured, a copy of the log within 30 days after receiving a request for the log from the insured or the assignee.

(f) Benefits paid pursuant to this section are overdue if not paid within 30 days after written notice of the fact and amount of a covered loss is furnished to the insurer.

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1. If written notice of the entire claim is not furnished to the insurer, any partial amount supported by the written notice is overdue if not paid within 30 days after the written notice is furnished. 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 subsequent written notice is furnished to the insurer.

2. This paragraph does not preclude or limit the ability of the insurer to assert that the claim or a portion of the claim was unrelated, was not medically necessary, or was unreasonable, or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion may be made at any time, including after payment of the claim or after the 30-day period for payment set forth in this paragraph.

3. If 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 has 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 if this information does not limit the introduction of evidence at trial. The insurer must also include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

4. Notwithstanding that written notice has been furnished to the insurer, payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment.


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5. For the purpose of calculating the extent to which benefits are overdue, payment shall be considered made on the date a draft or other valid instrument that 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.

6. All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of the covered loss. Interest is due at the time payment of the overdue claim is made.

(g) If two or more insurers are liable for paying emergency care coverage benefits for the same injury to any one person, the maximum amount payable shall be as specified in subsection (1), and an insurer paying the benefits is 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.

(h) In a dispute between the insured and the insurer, or between an assignee of the insured’s rights and the insurer, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(i) Benefits are not due or payable to or on behalf of an insured, claimant, medical provider, or attorney if the insured, claimant, medical provider, or attorney has:

1. Knowingly submitted a false material statement, document, record, or bill;


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2. Knowingly submitted false material information; or

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

A claimant who violates this paragraph is not entitled to any emergency care coverage benefits or payment for any bills and services, regardless of whether a portion of the claim may be legitimate. However, a medical provider who does not violate this paragraph may not be denied benefits solely due to violation by another claimant.

(j) If an insurer has a reasonable belief that a fraudulent insurance act, as defined in s. 626.989, has been committed and reports its suspicions to the Division of Insurance Fraud, the 30-day period for payment is tolled for any portions of the claim reported for investigation until the insurer receives notice from the Division of Insurance Fraud that the claim has been investigated and states whether a criminal action will be recommended.

1. The insurer must notify the claimant in writing that the claim is being investigated for fraud within 30 days after the insurer is furnished with written notice of the fact and amount of a covered loss. Within 30 days after receipt of notice from the Division of Insurance Fraud that a claim has been investigated and that no criminal action will be recommended, the insurer must pay the claim with simple interest as provided in subparagraph (f)6.

2. Subject to s. 626.989(4), persons or entities that in good faith report suspected fraud to the Division of Insurance Fraud or share information in the furtherance of a fraud


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investigation are not subject to any civil or criminal liability relating to the reporting or release of such information.

(k) 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.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by emergency care coverage insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services, treatment, supplies, and care rendered, and the insurer providing such coverage may pay such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment, or her or his guardian, has countersigned the properly completed invoice, bill, or claim form approved by the office attesting that such treatment has actually been rendered to the best knowledge of the insured or her or his guardian. However, such charge may not exceed the amount that the person or institution customarily charges for like services, treatment, supplies, or care. When determining whether a charge for a particular service, treatment, supply, or care is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the charges

for the service, treatment, supply, or care.

1. If a health care provider or entity bills an insurer an amount less than that indicated in the following schedule of maximum charges and the insurer pays the amount billed, the payment shall be considered reasonable. A payment made by an insurer that limits reimbursement to 80 percent of the following schedule of maximum charges is considered reasonable:

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

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

c. For emergency services and care provided in a hospital and 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, treatment, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B.

(II) For medical services, treatment, supplies, and care provided by clinical laboratories, Medicare Part B.

(III) For durable medical equipment, the Durable Medical Equipment Prosthetics/Orthortics & Supplies (DMEPOS) fee schedule of Medicare Part B.

However, if such services, treatment, supplies, or care is not reimbursable under Medicare Part B as provided in this sub-subparagraph, 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, treatment, supplies, or care is provided. Services, treatment, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation that was in effect on March 1 of the year and for the area in which the services, treatment, supplies, or care was rendered, and applies until March 1 of the following year, notwithstanding subsequent changes made to such 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, treatment, supplies, and care subject to Medicare Part B.

3. Subparagraph 1. 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


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subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of her or his license regardless of whether such provider is 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. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, treatment, 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 emergency care coverage insurance due to the coinsurance amount or maximum policy limits.

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

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

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

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

4. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

5. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in


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accordance with paragraph (e). To facilitate prompt payment of lawful services, an insurer may change billing codes that it determines have been improperly or incorrectly upcoded or unbundled and may make payment based on the changed billing codes without affecting the right of the provider to dispute the change by the insurer. However, before doing that, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding or make a reasonable good faith effort to do so as documented in the insurer's file; or

6. 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 her or his professional services and included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

(c) 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 emergency care coverage benefits under this section. The list 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 shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent 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

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charges or reimburse claims for any diagnostic test deemed not medically necessary by the Department of Health.

(d) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care 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. However, 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 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. If the insured fails to furnish the provider with the correct name and address of the insured's emergency care coverage insurer, the provider has 35 days after 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 which demonstrates that the provider

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reasonably relied on erroneous information from the insured and:

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. For emergency services and care 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 period established by this paragraph, and the insurer is not considered to have been furnished with notice of the amount of the covered loss for purposes of paragraph (4)(f) until it receives a statement complying with paragraph (e), or a copy thereof, which specifically identifies the place of service as a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services.

3. Each notice of the insured's rights under s. 627.7488 must include the following statement in at least 12-point type:

BILLING REQUIREMENTS.—Florida law provides 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


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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.

(e) All statements and bills for medical services rendered by a 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 form, 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, 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 CMS 1500 form instructions, the American Medical Association CPT Editorial Panel and the HCPCS. All providers, other than hospitals, must 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 CPT or HCPCS in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may

not include charges for the 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)(f), an insurer is not considered to have been furnished with notice of the amount of the covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

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

a. The insured or her or his guardian must countersign the form attesting to the fact that the services set forth in the form were actually rendered.

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

c. The insured or her or his 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 her or his guardian.

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain

percentage of any 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 her or his guardian so that the insured or her or his guardian countersigns the form with informed consent.

3. Countersignature by the insured or her or his guardian is not required for the reading of diagnostic tests or other services that 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, by her or his own hand, sign the form complying with this paragraph.

5. The completed original disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(f) and may not be electronically furnished.

6. The disclosure and acknowledgment form is not required for services billed by a provider for emergency services and care 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 a standard disclosure and acknowledgment form by rule to fulfill the requirements of this paragraph.

8. As used in this paragraph, the term "countersign" or "countersignature" means bearing a second or verifying signature, as on a previously signed document, and is not

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satisfied by the statement "signature on file" or similar statement.

9. This paragraph applies 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 is consistent with the services being rendered to the patient as claimed. The requirement to maintain 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.

(g) 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 whether 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 reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to a written notification by any person, the insurer shall pay to that person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, the insurer shall pay to that person 40 percent of the amount of the reduction, up to $500.

(h) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action


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constitutes a material misrepresentation under s. 626.9541(1)(i)2.

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

(a) In all circumstances, an insured seeking under ss. 627.748-627.7491, including omnibus insureds, must comply with the terms of the policy. Compliance with this paragraph is a condition precedent to the insured's recovering of benefits, except that an insured may not be required to submit to an examination under oath. If a request is made by an insurer providing emergency care coverage against whom a claim has been made, an employer must furnish a sworn statement, in a form approved by the office, of the earnings of the person upon whose injury the claim is based since the time of the bodily injury and for a reasonable period before the injury.

(b) If an insured seeking to recover benefits pursuant to ss. 627.748-627.7491 assigns the contractual right to such benefits or payment of such 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, except that an assignee may not be required to submit to an examination under oath.

(c) All claimants must produce and allow for the inspection of all documents requested by the insurer which are relevant to the services rendered and reasonably obtainable by the claimant.

(d) Each physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for emergency care coverage is based, any products, services, or accommodations relating to that or any other injury, or to a condition claimed to be connected with that or

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any other injury, shall, if requested by the insurer against whom the claim has been made, permit the insurer or the insurer's representative to conduct, within 10 days after the insurer's request, an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered, and shall furnish 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. The report shall be furnished with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and must identify which portion of the expenses for the treatment or services was incurred as a result of the bodily injury. The physician, hospital, clinic, or other medical institution shall also permit the inspection and copying of any records regarding such history, condition, treatment, dates, and costs of treatment; however, this does not limit the introduction of evidence at trial. The sworn statement must 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 cause of action for violation of the physician-patient privilege or invasion of the right of privacy is prohibited against any physician, hospital, clinic, or other medical institution complying with this paragraph. The person requesting such records and sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for

documentation or information within 30 days after having received notice of the amount of a covered loss under paragraph (4)(f), the amount or the partial amount that is the subject of the insurer's inquiry is overdue if the insurer does not pay in accordance with paragraph (4)(f) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An insurer that requests documentation or information pertaining to the reasonableness of charges or medical necessity without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code. Section 626.989(4)(d) applies to the sharing of information related to reviews and examinations conducted pursuant to this section.

(e) If there is a dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition the court to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must specify the time, place, manner, conditions, and scope of the discovery. The court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(f) Upon request, the injured person shall be furnished a copy of all information obtained by the insurer under this


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section and shall pay a reasonable charge if required by the insurer.

(g) Notice to an insurer of the existence of a claim may not be unreasonably withheld by an insured.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—If the mental or physical condition of an injured person covered by emergency care coverage is material to a claim that has been or may be made for past or future benefits under such coverage, upon the request of an insurer, such person must submit to mental or physical examination by a physician. The costs of such examination shall be borne entirely by the insurer. The insurer may include reasonable provisions in emergency care coverage insurance policies for the mental and physical examination of those claiming benefits under the policy.

(a) The examination must be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which means any location within the municipality in which the insured resides, or within 10 miles by road of the insured's residence if such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured but there is no qualified physician to conduct the examination in such location, the examination shall be conducted in an area that is in the closest proximity to the insured's residence.

(b) An insurer may not withdraw payment from a treating physician without the consent of the injured person covered by the policy unless the insurer first obtains a valid report by a

Florida physician licensed under the same chapter as the treating physician stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or who reviewed the treatment records of the injured person, is factually supported by the examination or treatment records reviewed, and that has not been modified by anyone other than the reviewing physician. The physician preparing the report must be in active practice, unless he or she is physically disabled. "Active practice" means that during the 3 years immediately preceding the date of the physical examination or review of treatment records, the physician devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school, accredited residency program, or a clinical research program that is affiliated with an accredited health professional school, teaching hospital, or accredited residency program. The insurer and any person acting at the direction of or on behalf of the insurer may not materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment resulting from a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2. This provision does not preclude the insurer from calling to the physician's attention any errors of fact in the report based upon information in the claim file.

(c) If requested by the person examined, a party causing an examination to be made must deliver a copy of every written

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report concerning a examination rendered by an examining physician to the person examined, at least one of which 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, relating to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her with respect to the same mental or physical condition.

(d) The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for emergency care coverage, or on behalf of an insured through an attorney or another entity, must maintain copies of all examination reports as medical records and all payments for the examinations and reports for at least 3 years.

(e) If a person unreasonably refuses to submit to an examination or fails to appear for an examination, the insurer is no longer liable for subsequent emergency care benefits. Refusal or failure to appear for two examinations raises a rebuttable presumption that such refusal or failure was unreasonable.

(8) DEMAND LETTER.—

(a) As a condition precedent to filing an action for benefits under this section, 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 subsection (4).

(b) The notice required must state that it is a "demand letter under s. 627.7485(8), F.S.," and state with specificity:

1. The name of the insured upon whom 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 the treatment, services, accommodations, or supplies to an insured which 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 (5)(e) or the lost-wage statement previously submitted may be used as the itemized statement. If the demand involves an insurer's withdrawal of payment under paragraph (7)(b) 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

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registered mail, return receipt requested. If requested by the claimant in the notice, such postal costs shall be reimbursed by the insurer when the insurer pays the claim. The 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 the name and address of the person to whom notices pursuant to this subsection are sent, which the office shall make available on its 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 no other designation has been made.

(d) If the overdue claim specified in the notice is paid by the insurer within 30 days after receipt of notice by the insurer, plus applicable interest and a penalty of 10 percent of the overdue amount, 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)(b) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after 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 not payable in any subsequent action. For purposes of this paragraph, payment or the insurer's agreement are considered made on the date a draft


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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 fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this paragraph.

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

(f) 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.

(9) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) If an insurer fails to pay valid claims for emergency care coverage with such frequency as to indicate a general business practice, the insurer is engaging in a prohibited unfair or deceptive practice subject to the penalties provided in s. 626.9521, and the office has the powers and duties specified in ss. 626.9561-626.9601 with respect thereto.

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(10) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo

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contendere to, insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for emergency care coverage in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768 and attorney fees and costs incurred in litigating the cause of action.

(11) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed advising that:

(a) 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.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing emergency care coverage or tort claims could be a violation of s. 817.234 or s. 817.505 or the rules regulating The Florida Bar and, if such conduct has taken place, should be immediately reported to the Division of Insurance Fraud.

(12) ALL CLAIMS BROUGHT IN A SINGLE ACTION.—In any civil action to recover emergency care coverage brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person

shall be brought in one action unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney fees to the claimant.

(13) SECURE ELECTRONIC DATA TRANSFER.—A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.748-627.7491 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Section 15. Section 627.7486, Florida Statutes, is created to read:

627.7486 Tort exemption; limitation on right to damages; punitive damages.—

(1) Every owner, registrant, operator, or occupant of a motor vehicle for which security has been provided as required by ss. 627.748-627.7491, and every person or organization legally responsible for her or his acts or omissions, is exempt from tort liability for damages because of bodily injury, sickness, or disease arising out of the ownership, operation, maintenance, or use of such motor vehicle in this state to the extent that the benefits described in s. 627.7485(1) are payable for such injury, or would be payable but for any exclusion authorized by ss. 627.748-627.7491, under any insurance policy or other method of security complying with s. 627.7483, or by an owner personally liable under s. 627.7483 for the payment of such benefits, unless the person is entitled to maintain an action for pain, suffering, mental anguish, and inconvenience

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for such injury under subsection (2).

(2) In any action of tort brought against the owner, registrant, operator, or occupant of a motor vehicle for which security has been provided as required by ss. 627.748-627.7491, or against any person or organization legally responsible for her or his acts or omissions, a plaintiff may recover damages in tort for pain, suffering, mental anguish, and inconvenience because of bodily injury, sickness, or disease arising out of the ownership, maintenance, operation, or use of such motor vehicle only if the injury or disease consists in whole or in part of:

(a) Significant and permanent loss of an important bodily function;

(b) Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement;

(c) Significant and permanent scarring or disfigurement; or

(d) Death.

(3) If a defendant in a proceeding brought pursuant to ss. 627.748-627.7491 questions whether the plaintiff has met the requirements of subsection (2), the defendant may file an appropriate motion with the court, and the court, 30 days before the date set for the trial or the pretrial hearing, whichever is first, shall, on a one-time basis only, ascertain by examining the pleadings and the evidence before it whether the plaintiff will be able to submit some evidence that the plaintiff will meet the requirements of subsection (2). If the court finds that the plaintiff will not be able to submit such evidence, the court shall dismiss the plaintiff’s claim without prejudice.

(4) A claim for punitive damages is not allowed in any

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action brought against a motor vehicle liability insurer for damages in excess of its policy limits.

Section 16. Section 627.7487, Florida Statutes, is created to read:

627.7487 Emergency care coverage; optional limitations; deductibles.—

(1) The named insured may elect a deductible or modified coverage or combination thereof to apply to the named insured alone or to the named insured and dependent relatives residing in the insured's household but may not elect a deductible or modified coverage to apply to any other person covered under the policy.

(2) Upon the renewal of an existing policy, an insurer shall offer deductibles of $250, $500, and $1,000 to each applicant and to each policyholder. The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.7485. After the deductible is met, each insured may receive up to $10,000 in total benefits as described in s. 627.7485(1). However, this subsection may not be applied to reduce the amount of any benefits received in accordance with s. 627.7485(1)(c).

(3) An insurer shall offer coverage where, at the election of the named insured, the benefits for loss of gross income and loss of earning capacity described in s. 627.7485(1)(b) are excluded.

(4) The named insured may not be prevented from electing a deductible under subsection (2) and modified coverage under subsection (3). Each election made by the named insured under this section must result in an appropriate reduction of premium

associated with that election.

(5) All such offers must be made in clear and unambiguous language at the time the initial application is taken and before each annual renewal and indicate that a premium reduction will result from each election. At the option of the insurer, such requirement may be met by using forms of notice approved by the office or by providing the following notice in 10-point type in the insurer's application for initial issuance of a policy of motor vehicle insurance and the insurer's annual notice of renewal premium:

For emergency care coverage insurance, the named insured may elect a deductible and may choose to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). This selection and choice apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

Section 17. Section 627.7488, Florida Statutes, is created to read:

627.7488 Notice of insured's rights.—

(1) The commission shall adopt by rule a form for notifying insureds of their right to receive coverage under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law. Such notice must include:

(a) A description of the benefits provided, including, but

not limited to, the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions from and limitations on coverage, how benefits are coordinated with other insurance benefits that the insured may have, when payments are due, penalties and interest that may be imposed on insurers for failure to make timely payments of benefits, and rights of parties regarding disputes as to benefits.

(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. 627.7485(5)(f)1.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.

(c) A notice that solicitation of a person injured in a motor vehicle crash for purposes of filing emergency care coverage or tort claims could be a violation of s. 817.234 or s. 817.505 or the rules regulating The Florida Bar and, if such conduct has taken place, it should be immediately reported to the Division of Insurance Fraud.

(2) Each insurer issuing a policy in this state providing emergency care coverage must mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving from the insured notice of a motor vehicle accident or

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claim involving personal injury to an insured who is covered under the policy. The office may allow an insurer additional time, not to exceed 30 days, to provide the notice specified in subsection (1) upon a showing by the insurer that an emergency justifies an extension of time.

(3) The notice required by this section does not alter or modify the terms of the insurance contract or other requirements of ss. 627.748-627.7491.

Section 18. Section 627.7489, Florida Statutes, is created to read:

627.7489 Mandatory joinder of derivative claim.—In any action brought pursuant to s. 627.7486 claiming personal injuries, all claims arising out of the plaintiff's injuries, including all derivative claims, shall be brought together, unless good cause is shown why such claims should be brought separately.

Section 19. Section 627.749, Florida Statutes, is created to read:

627.749 Insurers' right of reimbursement.—Notwithstanding any other provisions of ss. 627.748-627.7491, an insurer providing emergency care coverage on a private passenger motor vehicle shall, to the extent of any emergency care coverage paid to any person as a benefit arising out of such private passenger motor vehicle insurance, have a right of reimbursement against the owner or the insurer of the owner of a commercial motor vehicle if the benefits paid result from such person having been an occupant of the commercial motor vehicle or having been struck by the commercial motor vehicle while not an occupant of any self-propelled vehicle.


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Section 20. Section 627.7491, Florida Statutes, is created to read:

627.7491 Application of the Florida Motor Vehicle No-Fault Emergency Care Coverage Law.—

(1) On or after January 1, 2013, any person subject to ss. 627.748-627.7491 must maintain security for emergency care coverage.

(2) All forms and rates for policies issued or renewed on or after January 1, 2013, must reflect ss. 627.748-627.7491 and must be approved by the office before use.

(3) After January 1, 2013, insurers must provide notice of the Florida Motor Vehicle No-Fault Emergency Care Coverage Law to existing policyholders at least 30 days before the policy expiration date and to applicants for no-fault coverage upon receipt of the application. The notice is not subject to approval by the office and must clearly inform the policyholder or applicant of the following:

(a) That no-fault motor vehicle insurance requirements are governed by the Florida Motor Vehicle No-Fault Emergency Care Coverage Law and must provide an explanation of emergency care coverage. With respect to the initial renewal after January 1, 2013, current policyholders must also be provided with an explanation of differences between their current policies and the coverage provided under emergency care coverage policies.

(b) That failure to maintain required emergency care coverage and $10,000 in property damage liability coverage may result in state suspension of the policyholder’s driver license and vehicle registration.

(c) The name and telephone number of a person to contact


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with any questions she or he may have.

Section 21. Subsection (1), paragraph (c) of subsection (7), paragraphs (a), (b), and (c) of subsection (8), and subsections (9), (10), and (13) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(1)(a) A person commits insurance fraud punishable as provided in subsection (11) if that person, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; ~~or~~

3.a. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in


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support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract; or

b. ~~Who~~ Knowingly conceals information concerning any fact material to such application; or~~.~~

4. Knowingly presents, causes to be presented, or, with knowledge or belief that it will be presented to an insurer, prepares or makes a claim for payment or other benefit under a personal injury protection insurance policy or an emergency care overage insurance policy and the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400.

(b) All claims and application forms must ~~shall~~ contain a statement that is approved by the Office of Insurance Regulation of the Financial Services Commission which clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree." This paragraph does ~~shall~~ not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

(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(7) or s.


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627.7485(7), as applicable, ~~s. 627.736(8)~~ 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.

(8)(a) It is unlawful for any person intending to defraud any other person to solicit or cause to be solicited any business from a person involved in a motor vehicle accident for the purpose of making, adjusting, or settling motor vehicle tort claims or claims for personal injury protection or emergency care coverage benefits required by s. 627.736 or 627.7485, as applicable. Any person who violates ~~the provisions of~~ this paragraph commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

(b) A person may not solicit or cause to be solicited any business from a person involved in a motor vehicle accident by any means of communication other than advertising directed to the public for the purpose of making motor vehicle tort claims or claims for personal injury protection or emergency care coverage benefits required by s. 627.736 or 627.7485, as applicable, within 60 days after the occurrence of the motor vehicle accident. 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.

(c) A lawyer, health care practitioner as defined in s.


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456.001, or owner or medical director of a clinic required to be licensed pursuant to s. 400.9905 may not, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, solicit or cause to be solicited any business from a person involved in a motor vehicle accident by means of in person or telephone contact at the person's residence, for the purpose of making motor vehicle tort claims or claims for personal injury protection or emergency care coverage benefits required by s. 627.736 or 627.7485, as applicable. 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.

(9) A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash or a scheme to create documentation of a motor vehicle crash that did not occur for the purpose of making motor vehicle tort claims or claims for personal injury protection or emergency care coverage benefits as required by s. 627.736 or s. 627.7485, as applicable. Any person who violates this subsection commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

(10) A licensed health care practitioner who is found guilty of insurance fraud under this section for an act relating to a personal injury protection or emergency care coverage insurance policy may not be licensed or continue to be licensed for 5 years and may not receive reimbursement for benefits under such policies for 10 years. ~~As used in this section, the term~~


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~~"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.~~

(13) 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" means value as defined in s. 812.012.

Section 22. Subsection (4) of section 316.065, Florida Statutes, is amended to read:

316.065 Crashes; reports; penalties.—

(4) Any person who knowingly repairs a motor vehicle without having made a report as required by subsection (3) is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. The owner and driver of a vehicle involved in a crash who makes a report thereof in accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable under this section.

Section 23. Subsection (1) of section 316.646, Florida Statutes, is amended to read:

316.646 Security required; proof of security and display thereof; dismissal of cases.—

(1) Any person required by s. 324.022 to maintain property damage liability security, required by s. 324.023 to maintain liability security for bodily injury or death, ~~or~~ required by s.


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627.733 to maintain personal injury protection security, or required by s. 627.7483 to maintain emergency care coverage security, as applicable, on a motor vehicle must ~~shall~~ have in his or her immediate possession at all times while operating such motor vehicle proper proof of maintenance of the required security. Such proof must ~~shall~~ be a uniform proof-of-insurance card in a form prescribed by the department, a valid insurance policy, an insurance policy binder, a certificate of insurance, or such other proof as may be prescribed by the department.

Section 24. Paragraph (b) of subsection (2) of section 318.18, Florida Statutes, is amended to read:

318.18 Amount of penalties.—The penalties required for a noncriminal disposition pursuant to s. 318.14 or a criminal offense listed in s. 318.17 are as follows:

(2) Thirty dollars for all nonmoving traffic violations and:

(b) For all violations of ss. 320.0605, 320.07(1), 322.065, and 322.15(1). Any person who is cited for a violation of s. 320.07(1) shall be charged a delinquent fee pursuant to s. 320.07(4).

1. If a person who is cited for a violation of s. 320.0605 or s. 320.07 can show proof of having a valid registration at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10. A person who finds it impossible or impractical to obtain a valid registration certificate must submit an affidavit detailing the reasons for the impossibility or impracticality. The reasons may include, but are not limited to, the fact that the vehicle was sold, stolen, or destroyed; that the state in which the vehicle is

registered does not issue a certificate of registration; or that the vehicle is owned by another person.

2. If a person who is cited for a violation of s. 322.03, s. 322.065, or s. 322.15 can show a driver ~~driver's~~ license issued to him or her and valid at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10.

3. If a person who is cited for a violation of s. 316.646 can show proof of security as required by s. 627.733 or s. 627.7483, as applicable, issued to the person and valid at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10. A person who finds it impossible or impractical to obtain proof of security must submit an affidavit detailing the reasons for the impracticality. The reasons may include, but are not limited to, the fact that the vehicle has since been sold, stolen, or destroyed; that the owner or registrant of the vehicle is not required by s. 627.733 or s. 627.7483 to maintain personal injury protection insurance or emergency care coverage insurance, as applicable; or that the vehicle is owned by another person.

Section 25. Paragraphs (a) and (d) of subsection (5) of section 320.02, Florida Statutes, are amended to read:

320.02 Registration required; application for registration; forms.—

(5)(a) Proof that personal injury protection benefits or emergency care coverage benefits, as applicable, have been purchased if ~~when~~ required under s. 627.733 or s. 627.7483, as applicable, that property damage liability coverage has been


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purchased as required under s. 324.022, that bodily injury or death coverage has been purchased if required under s. 324.023, and that combined bodily liability insurance and property damage liability insurance have been purchased if ~~when~~ required under s. 627.7415 shall be provided in the manner prescribed by law by the applicant at the time of application for registration of any motor vehicle that is subject to such requirements. The issuing agent shall refuse to issue registration if such proof of purchase is not provided. Insurers shall furnish uniform proof-of-purchase cards in a form prescribed by the department and ~~shall~~ include the name of the insured's insurance company, the coverage identification number, and the make, year, and vehicle identification number of the vehicle insured. The card must ~~shall~~ contain a statement notifying the applicant of the penalty specified in s. 316.646(4). The card or insurance policy, insurance policy binder, or certificate of insurance or a photocopy of any of these; an affidavit containing the name of the insured's insurance company, the insured's policy number, and the make and year of the vehicle insured; or such other proof as may be prescribed by the department ~~shall~~ constitute sufficient proof of purchase. If an affidavit is provided as proof, it must ~~shall~~ be in substantially the following form:

Under penalty of perjury, I ...(Name of insured)... do hereby certify that I have ...(Personal Injury Protection or Emergency Care Coverage, as applicable, Property Damage Liability, and, if ~~when~~ required, Bodily Injury Liability)... Insurance currently in effect with ...(Name of insurance company)... under ...(policy number)... covering ...(make, year,


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and vehicle identification number of vehicle).... ...(Signature of Insured)...

The ~~Such~~ affidavit must ~~shall~~ include the following warning:

WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A VEHICLE REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER FLORIDA LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT IS SUBJECT TO PROSECUTION.

If ~~When~~ an application is made through a licensed motor vehicle dealer as required in s. 319.23, the original or a photostatic copy of such card, insurance policy, insurance policy binder, or certificate of insurance or the original affidavit from the insured shall be forwarded by the dealer to the tax collector of the county or the Department of Highway Safety and Motor Vehicles for processing. By executing the aforesaid affidavit, the ~~no~~ licensed motor vehicle dealer will not be liable in damages for any inadequacy, insufficiency, or falsification of any statement contained therein. A card must ~~shall~~ also indicate the existence of any bodily injury liability insurance voluntarily purchased.

(d) The verifying of proof of personal injury protection insurance or emergency care coverage insurance, as applicable, proof of property damage liability insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance and the issuance or failure to issue the motor vehicle registration


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under ~~the provisions of~~ this chapter may not be construed in any court as a warranty of the reliability or accuracy of the evidence of such proof. Neither the department nor any tax collector is liable in damages for any inadequacy, insufficiency, falsification, or unauthorized modification of any item of the proof of personal injury protection insurance or emergency care coverage insurance, as applicable, proof of property damage liability insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance before ~~prior to~~, during, or subsequent to the verification of the proof. The issuance of a motor vehicle registration does not constitute prima facie evidence or a presumption of insurance coverage.

Section 26. Paragraph (b) of subsection (1) of section 320.0609, Florida Statutes, is amended to read:

320.0609 Transfer and exchange of registration license plates; transfer fee.—

(1)

(b) The transfer of a license plate from a vehicle disposed of to a newly acquired vehicle does not constitute a new registration. The application for transfer shall be accepted without requiring proof of personal injury protection insurance or emergency care coverage insurance, as applicable, or liability insurance.

Section 27. Subsection (3) of section 320.27, Florida Statutes, is amended to read:

320.27 Motor vehicle dealers.—

(3) APPLICATION AND FEE.—The application for the license must ~~shall~~ be in such form as may be prescribed by the

department and ~~shall be~~ subject to such rules with respect thereto as may be so prescribed by it. Such application must ~~shall~~ be verified by oath or affirmation and ~~shall~~ contain a full statement of the name and birth date of the applicant ~~person or persons applying therefor~~; the name of the firm or copartnership, with the names and places of residence of all members thereof, if such applicant is a firm or copartnership; the names and places of residence of the principal officers, if the applicant is a body corporate or other artificial body; the name of the state under whose laws the corporation is organized; the present and former place or places of residence of the applicant; and prior business in which the applicant has been engaged and the location thereof. The ~~Such~~ application must ~~shall~~ describe the exact location of the place of business and ~~shall~~ state whether the place of business is owned by the applicant and if ~~when~~ acquired, or, if leased, a true copy of the lease must ~~shall~~ be attached to the application. The applicant shall certify that the location provides an adequately equipped office and is not a residence; that the location affords sufficient unoccupied space upon and within which to adequately ~~to~~ store all motor vehicles offered and displayed for sale; and that the location is a suitable place where the applicant can in good faith carry on such business and keep and maintain books, records, and files necessary to conduct such business, which will be available at all reasonable hours for ~~to~~ inspection by the department or ~~any of~~ its inspectors or other employees. The applicant shall certify that the business of a motor vehicle dealer is the principal business that will ~~which~~ ~~shall~~ be conducted at that location. The ~~Such~~ application must


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~~shall~~ contain a statement that the applicant is ~~either~~ franchised by a manufacturer of motor vehicles, in which case the name of each motor vehicle that the applicant is franchised to sell shall be included, or an independent, ~~(~~nonfranchised,~~)~~ motor vehicle dealer. The ~~Such~~ application must ~~shall~~ contain such other relevant information as may be required by the department, including evidence that the applicant is insured under a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy, which includes ~~shall include~~, at a minimum, $25,000 combined single-limit liability coverage including bodily injury and property damage protection and $10,000 personal injury protection or emergency care coverage, as applicable. Franchise dealers must submit a garage liability insurance policy, and all other dealers must submit a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy. The ~~Such~~ policy shall be for the license period, and evidence of a new or continued policy must ~~shall~~ be delivered to the department at the beginning of each license period. Upon making initial application, the applicant shall pay to the department a fee of $300 in addition to any other fees ~~now~~ required by law; upon making a subsequent renewal application, the applicant shall pay to the department a fee of $75 in addition to any other fees ~~now~~ required by law. Upon making an application for a change of location, the person shall pay a fee of $50 in addition to any other fees ~~now~~ required by law. The department shall, in the case of every application for initial licensure, verify whether certain facts set forth in the application are true. Each applicant, general partner in the


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case of a partnership, or corporate officer and director in the case of a corporate applicant, must file a set of fingerprints with the department for the purpose of determining any prior criminal record or any outstanding warrants. The department shall submit the fingerprints to the Department of Law Enforcement for state processing and forwarding to the Federal Bureau of Investigation for federal processing. The actual cost of state and federal processing shall be borne by the applicant and is in addition to the fee for licensure. The department may issue a license to an applicant pending the results of the fingerprint investigation, which ~~license~~ is fully revocable if the department subsequently determines that any facts set forth in the application are not true or correctly represented.

Section 28. Paragraph (j) of subsection (3) of section 320.771, Florida Statutes, is amended to read:

320.771 License required of recreational vehicle dealers.—

(3) APPLICATION.—The application for such license shall be in the form prescribed by the department and subject to such rules as may be prescribed by it. The application shall be verified by oath or affirmation and shall contain:

(j) A statement that the applicant is insured under a garage liability insurance policy, which ~~shall include~~, at a minimum, <u>includes</u> $25,000 combined single-limit liability coverage, including bodily injury and property damage protection, and $10,000 personal injury protection <u>or emergency care coverage, as applicable</u>, if the applicant is to be licensed as a dealer in, or intends to sell, recreational vehicles.

The department shall, if it deems necessary, cause an


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investigation to be made to ascertain if the facts set forth in the application are true and may ~~shall~~ not issue a license to the applicant until it is satisfied that the facts set forth in the application are true.

Section 29. Subsection (1) of section 322.251, Florida Statutes, is amended to read:

322.251 Notice of cancellation, suspension, revocation, or disqualification of license.—

(1) All orders of cancellation, suspension, revocation, or disqualification issued under ~~the provisions of~~ this chapter, chapter 318, chapter 324, ~~or~~ ss. 627.732-627.734, or ss. 627.748-627.7491 must be made ~~shall be given either~~ by personal delivery ~~thereof~~ to the licensee whose license is being canceled, suspended, revoked, or disqualified or by deposit in the United States mail in an envelope, first class, postage prepaid, addressed to the licensee at his or her last known mailing address furnished to the department. Such mailing by the department constitutes notification, and any failure by the person to receive the mailed order does ~~will~~ not affect or stay the effective date or term of the cancellation, suspension, revocation, or disqualification of the licensee's driving privilege.

Section 30. Paragraph (a) of subsection (8) of section 322.34, Florida Statutes, is amended to read:

322.34 Driving while license suspended, revoked, canceled, or disqualified.—

(8)(a) Upon the arrest of a person for the offense of driving while the person's driver ~~driver's~~ license or driving privilege is suspended or revoked, the arresting officer must


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~~shall~~ determine:

1. Whether the person's driver ~~driver's~~ license is suspended or revoked.

2. Whether the person's driver ~~driver's~~ license has remained suspended or revoked since a conviction for the offense of driving with a suspended or revoked license.

3. Whether the suspension or revocation was made under s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, relating to failure to maintain required security, or under s. 322.264, relating to habitual traffic offenders.

4. Whether the driver is the registered owner or coowner of the vehicle.

Section 31. Subsection (1) and paragraph (c) of subsection (9) of section 324.021, Florida Statutes, are 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. However, the term "motor vehicle" does ~~shall~~ not include a ~~any~~ motor vehicle as defined in s. 627.732(3) or s. 627.7482(9), as applicable, if ~~when~~ the owner of such vehicle has complied with


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~~the requirements of~~ ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, ~~inclusive,~~ unless ~~the provisions of~~ s. 324.051 applies ~~apply~~; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

(9) OWNER; OWNER/LESSOR.—

(c) *Application.*—

1. The limits on liability in subparagraphs (b)2. and 3. do not apply to an owner of motor vehicles that are used for commercial activity in the owner's ordinary course of business, other than a rental company that rents or leases motor vehicles. For purposes of this paragraph, the term "rental company" includes only an entity that is engaged in the business of renting or leasing motor vehicles to the general public and that rents or leases a majority of its motor vehicles to persons who have ~~with~~ no direct or indirect affiliation with the rental company. The term also includes a motor vehicle dealer that provides temporary replacement vehicles to its customers for up to 10 days. The term "rental company" also includes:

a. A related rental or leasing company that is a subsidiary of the same parent company as that of the renting or leasing company that rented or leased the vehicle.

b. The holder of a motor vehicle title or an equity interest in a motor vehicle title if the title or equity interest is held pursuant to or to facilitate an asset-backed securitization of a fleet of motor vehicles used solely in the business of renting or leasing motor vehicles to the general public and under the dominion and control of a rental company, as described in this subparagraph, in the operation of such rental company's business.


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2. ~~Furthermore,~~ With respect to commercial motor vehicles as defined in s. 627.732 or s. 627.7482, as applicable, the limits on liability in subparagraphs (b)2. and 3. do not apply if, at the time of the incident, the commercial motor vehicle is being used in the transportation of materials found to be hazardous for the purposes of the Hazardous Materials Transportation Authorization Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq., and that is required pursuant to such act to carry placards warning others of the hazardous cargo, unless at the time of lease or rental ~~either~~:

a. The lessee indicates in writing that the vehicle will not be used to transport materials found to be hazardous for the purposes of the Hazardous Materials Transportation Authorization Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq.; or

b. The lessee or other operator of the commercial motor vehicle has in effect insurance with limits of at least $5,000,000 combined property damage and bodily injury liability.

Section 32. Section 324.0221, Florida Statutes, is amended to read:

324.0221 Reports by insurers to the department; suspension of driver ~~driver's~~ license and vehicle registrations; reinstatement.—

(1)(a) Each insurer that has issued a policy providing personal injury protection or emergency care coverage or property damage liability coverage shall report the renewal, cancellation, or nonrenewal of the policy ~~thereof~~ to the department within 45 days after the effective date of each renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing personal injury protection or emergency care

coverage or property damage liability coverage to a named insured not previously insured by the insurer during that calendar year, the insurer shall report the issuance of the new policy to the department within 30 days. The report shall be in the form and format and contain any information required by the department and must be provided in a format that is compatible with the data processing capabilities of the department. The department may adopt rules regarding the form and documentation required. Failure by an insurer to file proper reports with the department as required by this subsection or rules adopted with respect to the requirements of this subsection constitutes a violation of the Florida Insurance Code. These records shall be used by the department only for enforcement and regulatory purposes, including the generation by the department of data regarding compliance by owners of motor vehicles with the requirements for financial responsibility coverage.

(b) With respect to an insurance policy providing personal injury protection or emergency care coverage or property damage liability coverage, each insurer shall notify the named insured, or the first-named insured in the case of a commercial fleet policy, in writing that any cancellation or nonrenewal of the policy will be reported by the insurer to the department. The notice must also inform the named insured that failure to maintain personal injury protection or emergency care coverage and property damage liability coverage on a motor vehicle as ~~when~~ required by law may result in the loss of registration and driving privileges in this state and inform the named insured of the amount of the reinstatement fees required by this section. This notice is for informational purposes only, and an insurer


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is not civilly liable for failing to provide this notice.

(2) The department shall suspend, after due notice and an opportunity to be heard, the registration and driver ~~driver's~~ license of any owner or registrant of a motor vehicle with respect to which security is required under s. ~~ss.~~ 324.022 and either s. 627.733 or s. 627.7483, as applicable, upon:

(a) The department's records showing that the owner or registrant of such motor vehicle did not have in full force and effect when required security that complies with the requirements of s. ~~ss.~~ 324.022 and either s. 627.733 or s. 627.7483, as applicable; or

(b) Notification by the insurer to the department, in a form approved by the department, of cancellation or termination of the required security.

(3) An operator or owner whose driver ~~driver's~~ license or registration has been suspended under this section or s. 316.646 may effect its reinstatement upon compliance with the requirements of this section and upon payment to the department of a nonrefundable reinstatement fee of $150 for the first reinstatement. The reinstatement fee is $250 for the second reinstatement and $500 for each subsequent reinstatement during the 3 years following the first reinstatement. A person reinstating her or his insurance under this subsection must also secure noncancelable coverage as described in ss. 324.021(8), 324.023, and 627.7275(2) and present proof to the appropriate person ~~proof~~ that the coverage is in force on a form adopted by the department, and such proof shall be maintained for 2 years. If the person does not have a second reinstatement within 3 years after her or his initial reinstatement, the reinstatement


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fee is $150 for the first reinstatement after that 3-year period. If a person's license and registration are suspended under this section or s. 316.646, only one reinstatement fee must be paid to reinstate the license and the registration. All fees shall be collected by the department at the time of reinstatement. The department shall issue proper receipts for such fees and ~~shall~~ promptly deposit those fees in the Highway Safety Operating Trust Fund. One-third of the fees collected ~~under this subsection~~ shall be distributed from the Highway Safety Operating Trust Fund to the local governmental entity or state agency that employed the law enforcement officer seizing the license plate pursuant to s. 324.201. The funds may be used by the local governmental entity or state agency for any authorized purpose.

Section 33. Paragraph (a) of subsection (1) of section 324.032, Florida Statutes, is amended to read:

324.032 Manner of proving financial responsibility; for-hire passenger transportation vehicles.—Notwithstanding the provisions of s. 324.031:

(1)(a) A person who is ~~either~~ the owner or a lessee required to maintain insurance under s. 627.733(1)(b) or s. 627.7483(1), as applicable, and who operates one or more taxicabs, limousines, jitneys, or any other for-hire passenger transportation vehicles may prove financial responsibility by furnishing satisfactory evidence of holding a motor vehicle liability policy that has~~, but with~~ minimum limits of $125,000/250,000/50,000.

Upon request by the department, the applicant must provide the


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department at the applicant's principal place of business in this state access to the applicant's underlying financial information and financial statements that provide the basis of the certified public accountant's certification. The applicant shall reimburse the requesting department for all reasonable costs incurred by it in reviewing the supporting information. The maximum amount of self-insurance permissible under this subsection is $300,000 and must be stated on a per-occurrence basis, and the applicant shall maintain adequate excess insurance issued by an authorized or eligible insurer licensed or approved by the Office of Insurance Regulation. All risks self-insured shall remain with the owner or lessee providing it, and the risks are not transferable to any other person, unless a policy complying with subsection (1) is obtained.

Section 34. Subsection (2) of section 324.171, Florida Statutes, is amended to read:

324.171 Self-insurer.—

(2) The self-insurance certificate must ~~shall~~ provide limits of liability insurance in the amounts specified under s. 324.021(7) or s. 627.7415 and ~~shall~~ provide personal injury protection or emergency care coverage under s. 627.733(3)(b) or s. 627.7483(3)(b), as applicable.

Section 35. Paragraph (g) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

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


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(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director must ~~shall~~ take immediate corrective action. If the clinic performs only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, and the American College of Radiology; and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to all personal injury protection insurance or emergency care coverage insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume ~~the~~ responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

Section 36. Subsection (28) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(28) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third


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party, an insurer, or the agency, for any Medicaid-covered injury, illness, goods, or services, including costs of related medical services ~~related thereto~~, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses before ~~prior to~~ death. The term includes, without limitation, collateral~~, as defined in this section~~, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance or personal injury protection or emergency care coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 37. Paragraph (f) of subsection (11) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(f) Notwithstanding any other provision in this section ~~to the contrary~~, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

1. After attorney ~~attorney's~~ fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.

2. The remaining amount of the recovery shall be paid to the recipient.

3. For purposes of calculating the agency's recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.

4. Notwithstanding any other provision of this section ~~to the contrary~~, the agency is ~~shall be~~ entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, emergency care coverage, personal injury protection, and casualty.

Section 38. 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 may ~~are~~


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not ~~authorized to~~ acquire or own medical records, but, ~~are authorized~~ under the confidentiality and disclosure requirements of this section, may ~~to~~ maintain those documents that are required by the part or chapter under which they are licensed or regulated:

(k) Persons or entities practicing under s. 627.736(7) or s. 627.7485(7), as applicable.

Section 39. Paragraphs (ee) and (ff) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(ee) With respect to making a personal injury protection or an emergency care coverage claim as required by s. 627.736 or s. 627.7485, respectively, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732 or s. 627.7482, as applicable.

(ff) With respect to making a personal injury protection or an emergency care coverage claim as required by s. 627.736 or s. 627.7485, respectively, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

Section 40. Paragraph (o) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition


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and unfair or deceptive acts or practices:

(o) *Illegal dealings in premiums; excess or reduced charges for insurance.*—

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the office, and as specified in the policy; or, if ~~in cases when~~ classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges collected from a Florida resident in excess of or less than those specified in the policy and as fixed by the insurer. This provision may ~~shall~~ not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph does ~~shall~~ not ~~be construed to~~ prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in


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accordance with the terms of the contract.

3.~~a.~~ Imposing or requesting an additional premium for a policy of motor vehicle liability, emergency care coverage, personal injury protection, medical payment, or collision insurance or any combination thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

a.~~b.~~ An insurer which imposes and collects such a surcharge or which refuses to renew such policy shall, in conjunction with the notice of premium due or notice of nonrenewal, notify the named insured that he or she is entitled to reimbursement of such amount or renewal of the policy under the conditions listed below and will subsequently reimburse him or her or renew the policy~~,~~ if the named insured demonstrates that the operator involved in the accident was:

(I) Lawfully parked;

(II) Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;

(III) Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;

(IV) Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;

(V) Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving


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traffic violation;

(VI) Finally adjudicated not to be liable by a court of competent jurisdiction;

(VII) In receipt of a traffic citation that ~~which~~ was dismissed or nolle prossed; or

(VIII) Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

b.~~c.~~ In addition to the other provisions of this subparagraph, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current 3-year period. However, an insurer may nonrenew a policy for reasons other than accidents in accordance with s. 627.728. This subparagraph does not prohibit nonrenewal of a policy under which the insured has had three or more accidents, regardless of fault, during the most recent 3-year period.

4. Imposing or requesting an additional premium for, or refusing to renew, a policy for motor vehicle insurance solely because the insured committed a noncriminal traffic infraction as described in s. 318.14 unless the infraction is:

a. A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.

b. A violation of s. 316.183, if ~~when~~ such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.


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5. Upon the request of the insured, the insurer and licensed agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

6. Imposing or requesting ~~No insurer shall impose or request~~ an additional premium for motor vehicle insurance, cancelling or refusing ~~cancel or refuse~~ to issue a policy, or refusing ~~refuse~~ to renew a policy because the insured or the applicant is a handicapped or physically disabled person if~~, so long as~~ such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

7. Cancelling ~~No insurer may cancel~~ or otherwise terminating an ~~terminate any~~ insurance contract or coverage, or requiring ~~require~~ execution of a consent to rate endorsement, during the stated policy term for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. Issuing ~~No insurer may issue~~ a nonrenewal notice on any insurance contract or coverage, or requiring ~~require~~ execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

9. ~~No insurer shall,~~ With respect to premiums charged for motor vehicle insurance, unfairly discriminating ~~discriminate~~


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solely on the basis of age, sex, marital status, or scholastic achievement.

10. Imposing or requesting an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

11. Cancelling or issuing ~~No insurer shall cancel or issue~~ a nonrenewal notice on any insurance policy or contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

12. Imposing or requesting ~~No insurer shall impose or request~~ an additional premium, cancelling ~~cancel~~ a policy, or issuing ~~issue~~ a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

Section 41. Subsection (5) of section 626.9894, Florida Statutes, is amended to read:

626.9894 Gifts and grants.—

(5) Notwithstanding ~~the provisions of~~ s. 216.301 and pursuant to s. 216.351, any balance of moneys deposited into the Insurance Regulatory Trust Fund pursuant to this section or s. 626.9895 remaining at the end of any fiscal year is ~~shall be~~ available for carrying out the duties and responsibilities of the division. The department may request annual appropriations from the grants and donations received pursuant to this section or s. 626.9895 and cash balances in the Insurance Regulatory


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Trust Fund for the purpose of carrying out its duties and responsibilities related to the division's anti-fraud efforts, including the funding of dedicated prosecutors and related personnel.

Section 42. Subsection (1) of section 627.06501, Florida Statutes, is amended to read:

627.06501 Insurance discounts for certain persons completing driver improvement course.—

(1) Any rate, rating schedule, or rating manual for the liability, emergency care coverage, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office may provide for an appropriate reduction in premium charges as to such coverages if ~~when~~ the principal operator on the covered vehicle has successfully completed a driver improvement course approved and certified by the Department of Highway Safety and Motor Vehicles which is effective in reducing crash or violation rates, or both, as determined pursuant to s. 318.1451(5). Any discount, not to exceed 10 percent, used by an insurer is presumed to be appropriate unless credible data demonstrates otherwise.

Section 43. Subsection (1) of section 627.0652, Florida Statutes, is amended to read:

627.0652 Insurance discounts for certain persons completing safety course.—

(1) Any rates, rating schedules, or rating manuals for the liability, emergency care coverage, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office must ~~shall~~ provide for an appropriate reduction in premium charges as to such coverages if ~~when~~ the


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principal operator on the covered vehicle is an insured 55 years of age or older who has successfully completed a motor vehicle accident prevention course approved by the Department of Highway Safety and Motor Vehicles. Any discount used by an insurer is presumed to be appropriate unless credible data demonstrates otherwise.

Section 44. Subsections (1) and (3) of section 627.0653, Florida Statutes, are amended to read:

627.0653 Insurance discounts for specified motor vehicle equipment.—

(1) Any rates, rating schedules, or rating manuals for the liability, emergency care coverage, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office must ~~shall~~ provide a premium discount if the insured vehicle is equipped with factory-installed, four-wheel antilock brakes.

(3) Any rates, rating schedules, or rating manuals for emergency care coverage, personal injury protection coverage, and medical payments coverage, if offered, of a motor vehicle insurance policy filed with the office shall provide a premium discount if the insured vehicle is equipped with one or more air bags that ~~which~~ are factory installed.

Section 45. Section 627.4132, Florida Statutes, is amended to read:

627.4132 Stacking of coverages prohibited.—If an insured or named insured is protected by any type of motor vehicle insurance policy for liability, emergency care coverage, personal injury protection, or other coverage, the policy must ~~shall~~ provide that the insured or named insured is protected


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only to the extent of the coverage she or he has on the vehicle involved in the accident. However, if none of the insured's or named insured's vehicles is involved in the accident, coverage is available only to the extent of coverage on any one of the vehicles with applicable coverage. Coverage on any other vehicles may ~~shall~~ not be added to or stacked upon that coverage. This section does not apply:

(1) To uninsured motorist coverage that ~~which~~ is separately governed by s. 627.727.

(2) To reduce the coverage available by reason of insurance policies insuring different named insureds.

Section 46. Subsection (6) of section 627.6482, Florida Statutes, is amended to read:

627.6482 Definitions.—As used in ss. 627.648-627.6498, the term:

(6) "Health insurance" means any hospital and medical expense incurred policy, minimum premium plan, stop-loss coverage, health maintenance organization contract, prepaid health clinic contract, multiple-employer welfare arrangement contract, or fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract. The term does not include a ~~any~~ policy covering medical payment coverage or emergency care coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, or workers' compensation.

Section 47. Section 627.7263, Florida Statutes, is amended to read:

627.7263 Rental and leasing driver ~~driver's~~ insurance to be

primary; exception.—

(1) The valid and collectible liability insurance, emergency care coverage insurance, or personal injury protection insurance providing coverage for the lessor of a motor vehicle for rent or lease is primary unless otherwise stated in at least 10-point type on the face of the rental or lease agreement. Such insurance is primary for the limits of liability and personal injury protection or emergency care coverage as required by s. ~~ss.~~ 324.021(7) and either s. 627.736 or s. 627.7485, as applicable.

(2) If the lessee's coverage is to be primary, the rental or lease agreement must contain the following language, in at least 10-point type:

"The valid and collectible liability insurance and personal injury protection insurance or emergency care coverage insurance, as applicable, of an ~~any~~ authorized rental or leasing driver is primary for the limits of liability and personal injury protection or emergency care coverage required by s. ~~ss.~~ 324.021(7) and either s. 627.736 or s. 627.7485, Florida Statutes, as applicable."

Section 48. Subsections (1) and (7) of section 627.727, Florida Statutes, are amended to read:

627.727 Motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.—

(1) A ~~No~~ motor vehicle liability insurance policy which provides bodily injury liability coverage may not ~~shall~~ be

delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or principally garaged in this state unless uninsured motor vehicle coverage is provided therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom. However, the coverage required under this section is not applicable if ~~when~~, or to the extent that, an insured named in the policy makes a written rejection of the coverage on behalf of all insureds under the policy. If ~~When~~ a motor vehicle is leased for ~~a period of~~ 1 year or longer and the lessor ~~of such vehicle~~, by the terms of the lease contract, provides liability coverage on the leased vehicle, the lessee ~~of such vehicle~~ shall have the sole privilege to reject uninsured motorist coverage or to select lower limits than the bodily injury liability limits, regardless of whether the lessor is qualified as a self-insurer pursuant to s. 324.171. Unless an insured, or lessee having the privilege of rejecting uninsured motorist coverage, requests such coverage or requests higher uninsured motorist limits in writing, the coverage or such higher uninsured motorist limits need not be provided in or supplemental to any other policy that ~~which~~ renews, extends, changes, supersedes, or replaces an existing policy with the same bodily injury liability limits if ~~when~~ an insured or lessee had rejected the coverage. If ~~When~~ an insured or lessee has initially selected limits of uninsured motorist coverage lower than her or his bodily injury liability limits, higher limits of uninsured motorist coverage need not be

provided in or supplemental to any other policy that ~~which~~ renews, extends, changes, supersedes, or replaces an existing policy with the same bodily injury liability limits unless an insured requests higher uninsured motorist coverage in writing. The rejection or selection of lower limits shall be made on a form approved by the office. The form must ~~shall~~ fully advise the applicant of the nature of the coverage and ~~shall~~ state that the coverage is equal to bodily injury liability limits unless lower limits are requested or the coverage is rejected. The heading of the form must ~~shall~~ be in 12-point bold type and ~~shall~~ state: "You are electing not to purchase certain valuable coverage that ~~which~~ protects you and your family or you are purchasing uninsured motorist limits less than your bodily injury liability limits when you sign this form. Please read carefully." If this form is signed by a named insured, it will be conclusively presumed that there was an informed, knowing rejection of coverage or election of lower limits on behalf of all insureds. The insurer shall notify the named insured at least annually of her or his options as to the coverage required by this section. Such notice must ~~shall~~ be part of, and attached to, the notice of premium, ~~shall~~ provide for a means to allow the insured to request such coverage, and ~~shall~~ be given in a manner approved by the office. Receipt of this notice does not constitute an affirmative waiver of the insured's right to uninsured motorist coverage if ~~where~~ the insured has not signed a selection or rejection form. The coverage described under this section shall be over and above, but may ~~shall~~ not duplicate, the benefits available to an insured under any workers' compensation law, emergency care coverage or personal injury

protection benefits, disability benefits law, or similar law; under any automobile medical expense coverage; under any motor vehicle liability insurance coverage; or from the owner or operator of the uninsured motor vehicle or any other person or organization jointly or severally liable together with such owner or operator for the accident; and such coverage must ~~shall~~ cover the difference, if any, between the sum of such benefits and the damages sustained, up to the maximum amount of ~~such~~ coverage provided under this section. The amount of coverage available under this section may ~~shall~~ not be reduced by a setoff against any coverage, including liability insurance. Such coverage may ~~shall~~ not inure directly or indirectly to the benefit of any workers' compensation or disability benefits carrier or any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or similar law.

(7) The legal liability of an uninsured motorist coverage insurer does not include damages in tort for pain, suffering, mental anguish, and inconvenience unless the injury or disease is described in one or more of paragraphs (a)-(d) of s. 627.737(2) or paragraphs (a)-(d) of s. 627.7486(2).

Section 49. Subsection (1) of section 627.7275, Florida Statutes, is amended to read:

627.7275 Motor vehicle liability.—

(1) A motor vehicle insurance policy providing personal injury protection as set forth in s. 627.736 or emergency care coverage as set forth in s. 627.7485 may not be delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or

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principally garaged in this state unless the policy also provides coverage for property damage liability as required by s. 324.022.

Section 50. Paragraph (a) of subsection (1) of section 627.728, Florida Statutes, is amended to read:

627.728 Cancellations; nonrenewals.—

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

(a) "Policy" means the bodily injury and property damage liability, emergency care coverage, personal injury protection, medical payments, comprehensive, collision, and uninsured motorist coverage portions of a policy of motor vehicle insurance delivered or issued for delivery in this state:

1. Insuring a natural person as named insured or one or more related individuals resident of the same household; and

2. Insuring only a motor vehicle of the private passenger type or station wagon type which is not used as a public or livery conveyance for passengers or rented to others; or insuring any other four-wheel motor vehicle having a load capacity of 1,500 pounds or less which is not used in the occupation, profession, or business of the insured other than farming; other than any policy issued under an automobile insurance assigned risk plan; insuring more than four automobiles; or covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

The term "policy" does not include a binder as defined in s. 627.420 unless the duration of the binder period exceeds 60 days.


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Section 51. Subsection (1), paragraph (a) of subsection (5), and subsections (6) and (7) of section 627.7295, Florida Statutes, are amended to read:

627.7295 Motor vehicle insurance contracts.—

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

(a) "Policy" means a motor vehicle insurance policy that provides personal injury protection or emergency care coverage, or property damage liability coverage, or both.

(b) "Binder" means a binder that provides motor vehicle personal injury protection or emergency care coverage and property damage liability coverage.

(5)(a) A licensed general lines agent may charge a per-policy fee of up to ~~not to exceed~~ $10 to cover the administrative costs of the agent associated with selling the motor vehicle insurance policy if the policy covers only personal injury protection or emergency care coverage as provided by s. 627.736 or s. 627.7485, as applicable, and property damage liability coverage as provided by s. 627.7275 and if no other insurance is sold or issued in conjunction with or collateral to the policy. The fee is not considered part of the premium.

(6) If a motor vehicle owner's driver license, license plate, and registration have previously been suspended pursuant to s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, an insurer may cancel a new policy only as provided in s. 627.7275.

(7) A policy of private passenger motor vehicle insurance or a binder for such a policy may be initially issued in this state only if, before the effective date of such binder or policy, the insurer or agent ~~has~~ collected from the insured an


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amount equal to 2 months' premium. An insurer, agent, or premium finance company may not, directly or indirectly, take any action resulting in the insured paying ~~having paid~~ from the insured's own funds an amount less than the 2 months' premium required by this subsection. This subsection applies without regard to whether the premium is financed by a premium finance company or is paid pursuant to a periodic payment plan of an insurer or an insurance agent.

(a) This subsection does not apply:

1. If an insured or member of the insured's family is renewing or replacing a policy or a binder for such policy written by the same insurer or a member of the same insurer group. ~~This subsection does not apply~~

2. To an insurer that issues private passenger motor vehicle coverage primarily to active duty or former military personnel or their dependents. ~~This subsection does not apply~~

3. If all policy payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer payment plan from the policyholder.

(b) This subsection and subsection (4) do not apply

1. If all policy payments to an insurer are paid pursuant to an automatic electronic funds transfer payment plan from an agent, a managing general agent, or a premium finance company and if the policy includes, at a minimum, personal injury protection or emergency care coverage pursuant to ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable; motor vehicle property damage liability pursuant to s. 627.7275; and bodily injury liability in at least the amount of $10,000 because of bodily injury to, or death of, one person in any one accident


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and in the amount of $20,000 because of bodily injury to, or death of, two or more persons in any one accident. ~~This subsection and subsection (4) do not apply~~

2. If an insured has had a policy in effect for at least 6 months, the insured's agent is terminated by the insurer that issued the policy, and the insured obtains coverage on the policy's renewal date with a new company through the terminated agent.

Section 52. Subsections (1), (2), and (3) of section 627.737, Florida Statutes, are amended to read:

627.737 Tort exemption; limitation on right to damages; punitive damages.—

(1) Every owner, registrant, operator, or occupant of a motor vehicle with respect to which security has been provided as required by ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, and every person or organization legally responsible for her or his acts or omissions, is ~~hereby~~ exempted from tort liability for damages because of bodily injury, sickness, or disease arising out of the ownership, operation, maintenance, or use of such motor vehicle in this state to the extent that the benefits described in s. 627.736(1) or s. 627.7485(1), as applicable, are payable for such injury, or would be payable but for any exclusion authorized by ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, under any insurance policy or other method of security complying with the requirements of s. 627.733, or by an owner personally liable under s. 627.733 for the payment of such benefits, unless a person is entitled to maintain an action for pain, suffering, mental anguish, and inconvenience for such injury under the provisions of subsection

(2).

(2) In any action of tort brought against the owner, registrant, operator, or occupant of a motor vehicle with respect to which security has been provided as required by ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, or against any person or organization legally responsible for her or his acts or omissions, a plaintiff may recover damages in tort for pain, suffering, mental anguish, and inconvenience because of bodily injury, sickness, or disease arising out of the ownership, maintenance, operation, or use of such motor vehicle only if ~~in the event that~~ the injury or disease consists in whole or in part of:

(a) Significant and permanent loss of an important bodily function.

(b) Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.

(c) Significant and permanent scarring or disfigurement.

(d) Death.

(3) If ~~When~~ a defendant, in a proceeding brought pursuant to ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, questions whether the plaintiff has met the requirements of subsection (2), ~~then~~ the defendant may file an appropriate motion with the court, and the court shall, on a one-time basis only, 30 days before the date set for the trial or the pretrial hearing, whichever is first, by examining the pleadings and the evidence before it, ascertain whether the plaintiff will be able to submit some evidence that the plaintiff will meet the requirements of subsection (2). If the court finds that the plaintiff will not be able to submit such evidence, ~~then~~ the


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court shall dismiss the plaintiff's claim without prejudice.

Section 53. Section 627.8405, Florida Statutes, is amended to read:

627.8405 Prohibited acts; financing companies.—A ~~No~~ premium finance company ~~shall~~, in a premium finance agreement or other agreement, may not finance the cost of or otherwise provide for the collection or remittance of dues, assessments, fees, or other periodic payments of money for the cost of:

(1) A membership in an automobile club. The term "automobile club" means a legal entity that ~~which~~, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, this definition of "automobile club" does not include persons, associations, or corporations that ~~which~~ are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon racecourses established and marked as such for the duration of such particular events. The term ~~words~~ "motor vehicle" has ~~used herein have~~ the same meaning as provided ~~defined~~ in s. 320.01 ~~chapter 320~~.

(2) An accidental death and dismemberment policy sold in combination with a personal injury protection and property damage only policy or an emergency care and property damage only policy, as applicable.

(3) Any product not regulated under the ~~provisions of this~~ insurance code.


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This section also applies to premium financing by any insurance agent or insurance company under part XVI. The commission shall adopt rules to assure disclosure, at the time of sale, of coverages financed with personal injury protection or emergency care coverage and ~~shall~~ prescribe the form of such disclosure.

Section 54. Subsection (1) of section 627.915, Florida Statutes, is amended to read:

627.915 Insurer experience reporting.—

(1) Each insurer transacting private passenger automobile insurance in this state shall report certain information annually to the office. The information is ~~will be~~ due on or before July 1 of each year. The information shall be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; emergency care coverage or personal injury protection benefits; medical payments; comprehensive and collision. The information given must ~~shall~~ be on direct insurance writings in the state alone and ~~shall~~ represent total limits data. The information set forth in paragraphs (a)-(f) is applicable to voluntary private passenger and Joint Underwriting Association private passenger writings and must ~~shall~~ be reported for each of the latest 3 calendar-accident years, with an evaluation date of March 31 of the current year. The information set forth in paragraphs (g)-(j) is applicable to voluntary private passenger writings and must ~~shall~~ be reported on a calendar-accident year basis ultimately seven times at seven different stages of development.

(a) Premiums earned for the latest 3 calendar-accident years.

(b) Loss development factors and the historic development

of those factors.

(c) Policyholder dividends incurred.

(d) Expenses for other acquisition and general expense.

(e) Expenses for agents' commissions and taxes, licenses, and fees.

(f) Profit and contingency factors as used ~~utilized~~ in the insurer's automobile rate filings for the applicable years.

(g) Losses paid.

(h) Losses unpaid.

(i) Loss adjustment expenses paid.

(j) Loss adjustment expenses unpaid.

Section 55. Paragraph (d) of subsection (2) and paragraph (d) 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:

(d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as applicable, if ~~when~~ no-fault coverage is provided.

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

(d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as applicable, if ~~when~~ no-fault coverage is provided.

Section 56. Subsections (2) and (6) and paragraphs (a), (c), and (d) of subsection (7) of section 705.184, Florida Statutes, are amended to read:


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705.184 Derelict or abandoned motor vehicles on the premises of public-use airports.—

(2) The airport director or the director's designee shall contact the Department of Highway Safety and Motor Vehicles to notify that department that the airport has possession of the abandoned or derelict motor vehicle and to determine the name and address of the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and any person who has filed a lien on the motor vehicle. Within 7 business days after receipt of the information, the director or the director's designee shall send notice by certified mail, return receipt requested, to the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle. The notice must ~~shall~~ state the fact of possession of the motor vehicle, that charges for reasonable towing, storage, and parking fees, if any, have accrued and the amount thereof, that a lien as provided in subsection (6) will be claimed, that the lien is subject to enforcement pursuant to law, that the owner or lienholder, if any, has the right to a hearing as set forth in subsection (4), and that any motor vehicle that ~~which~~, at the end of 30 calendar days after receipt of the notice, has not been removed from the airport upon payment in full of all accrued charges for reasonable towing, storage, and parking fees, if any, may be disposed of as provided in s. 705.182(2)(a), (b), (d), or (e), including, but not limited to, ~~the motor vehicle~~ being sold free of all prior liens after 35


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calendar days after the time the motor vehicle is stored if any prior liens on the motor vehicle are more than 5 years of age or after 50 calendar days after the time the motor vehicle is stored if any prior liens on the motor vehicle are 5 years of age or less.

(6) The airport pursuant to this section or, if used, a licensed independent wrecker company pursuant to s. 713.78 shall have a lien on an abandoned or derelict motor vehicle for all reasonable towing, storage, and accrued parking fees, if any, except that a ~~no~~ storage fee may not ~~shall~~ be charged if the motor vehicle is stored less than 6 hours. As a prerequisite to perfecting a lien under this section, the airport director or the director's designee must serve ~~a~~ notice in accordance with subsection (2) on the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle. If attempts to notify the owner, the insurance company insuring the motor vehicle, ~~notwithstanding the provisions of s. 627.736,~~ or lienholders are not successful, the requirement of notice by mail shall be considered met. Serving of the notice does not dispense with recording the claim of lien.

(7)(a) For the purpose of perfecting its lien under this section, the airport shall record a claim of lien which shall state:

1. The name and address of the airport.

2. The name of the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and


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all persons of record claiming a lien against the motor vehicle.

3. The costs incurred from reasonable towing, storage, and parking fees, if any.

4. A description of the motor vehicle sufficient for identification.

(c) The claim of lien shall be sufficient if it is in substantially the following form:

CLAIM OF LIEN

State of ....

County of ....

Before me, the undersigned notary public, personally appeared ...., who was duly sworn and says that he/she is the .... of ...., whose address is....; and that the following described motor vehicle:

...(Description of motor vehicle)...

owned by ...., whose address is ...., has accrued $.... in fees for a reasonable tow, for storage, and for parking, if applicable; that the lienor served its notice to the owner, the insurance company insuring the motor vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, Florida Statutes, as applicable, and all persons of record claiming a lien against the motor vehicle on ...., ...(year)..., by.....

...(Signature)...

Sworn to (or affirmed) and subscribed before me this .... day of ...., ...(year)..., by ...(name of person making statement)....

...(Signature of Notary Public).....(Print, Type, or Stamp Commissioned name of Notary Public)...

Personally Known....OR Produced....as identification.


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However, the negligent inclusion or omission of any information in this claim of lien which does not prejudice the owner does not constitute a default that operates to defeat an otherwise valid lien.

(d) The claim of lien shall be served on the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, if no-fault coverage is provided, and all persons of record claiming a lien against the motor vehicle. If attempts to notify the owner, the insurance company insuring the motor vehicle ~~notwithstanding the provisions of s. 627.736~~, or lienholders are not successful, the requirement of notice by mail shall be considered met. The claim of lien shall be so served before recordation.

Section 57. Paragraphs (a), (b), and (c) of subsection (4) of section 713.78, Florida Statutes, are amended to read:

713.78 Liens for recovering, towing, or storing vehicles and vessels.—

(4)(a) Any person regularly engaged in the business of recovering, towing, or storing vehicles or vessels who comes into possession of a vehicle or vessel pursuant to subsection (2), and who claims a lien for recovery, towing, or storage services, must ~~shall~~ give notice to the registered owner, the insurance company insuring the vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and to all persons claiming a lien thereon, as disclosed by the records in the Department of Highway Safety and Motor Vehicles or of a corresponding agency in any other state.


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(b) If a ~~Whenever any~~ law enforcement agency authorizes the removal of a vehicle or vessel or if ~~whenever~~ any towing service, garage, repair shop, or automotive service, storage, or parking place notifies the law enforcement agency of possession of a vehicle or vessel pursuant to s. 715.07(2)(a)2., the law enforcement agency of the jurisdiction where the vehicle or vessel is stored shall contact the Department of Highway Safety and Motor Vehicles, or the appropriate agency of the state of registration, if known, within 24 hours through the medium of electronic communications, giving the full description of the vehicle or vessel. Upon receipt of the full description of the vehicle or vessel, the department shall search its files to determine the owner's name, the insurance company insuring the vehicle or vessel, and whether any person has filed a lien upon the vehicle or vessel as provided in s. 319.27(2) and (3) and notify the applicable law enforcement agency within 72 hours. The person in charge of the towing service, garage, repair shop, or automotive service, storage, or parking place shall obtain such information from the applicable law enforcement agency within 5 days after the date of storage and ~~shall~~ give notice pursuant to paragraph (a). The department may release the insurance company information to the requestor notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable.

(c) Notice by certified mail, return receipt requested, shall be sent within 7 business days after the date of storage of the vehicle or vessel to the registered owner, the insurance company insuring the vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the vehicle or vessel. The notice


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must ~~It shall~~ state the fact of possession of the vehicle or vessel, that a lien as provided in subsection (2) is claimed, that charges have accrued and the amount thereof, that the lien is subject to enforcement pursuant to law, and that the owner or lienholder, if any, has the right to a hearing as set forth in subsection (5), and that any vehicle or vessel that ~~which~~ remains unclaimed, or for which the charges for recovery, towing, or storage services remain unpaid, may be sold free of all prior liens after 35 days if the vehicle or vessel is more than 3 years of age or after 50 days if the vehicle or vessel is 3 years of age or less.

Section 58. The Office of Insurance Regulation shall perform a data call relating to coverage under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law and publish the results by January 1, 2015. It is the intent of the Legislature that the office design the data call with the expectation that the Legislature will use the data to help evaluate market conditions relating to motor vehicle insurance and the impact on the market of reforms made by this act. The elements of the data call must address, but need not be limited to, the following components of the new law:

(1) Quantity of claims.

(2) Type or nature of claimants.

(3) Amount and type of benefits paid and expenses incurred.

(4) Type and quantity of, and charges for, medical benefits.

(5) Attorney fees related to bringing and defending actions for benefits.

(6) Direct earned premiums for emergency care coverage,

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pure loss ratios, pure premiums, and other information related to premiums and losses.

(7) Licensed drivers and accidents.

(8) Fraud and enforcement.

Section 59. Any motor vehicle policy issued or renewed on or after January 1, 2013, is subject to and deemed to incorporate the Florida Motor Vehicle No-Fault Emergency Care Coverage Law as created by this act and is not subject to ss. 627.730-627.7405, the Florida Motor Vehicle No-Fault Act.

Section 60. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 61. This act shall take effect January 1, 2013.

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

And the title is amended as follows:

Delete lines 14 - 96

and insert:

injury protection and emergency care coverage benefits; amending s. 400.991, F.S.; requiring that an application for licensure, or exemption from licensure, as a health care clinic include a statement regarding insurance fraud; amending s. 626.989, F.S.; providing that knowingly submitting false, misleading, or fraudulent documents relating to licensure as a health care clinic, or submitting a claim for personal

injury protection or emergency care coverage relating to clinic licensure documents, is a fraudulent insurance act under certain conditions; creating s. 626.9895, F.S.; providing definitions; authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for, and duties of, the organization; requiring that the organization operate pursuant to a contract with the division; providing for the requirements of the contract; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; requiring that the department adopt rules relating to procedures for the organization's governance and relating to conditions for the use of the division's property or facilities; authorizing contributions from insurers; authorizing any moneys received by the organization to be held in a separate depository account in the name of the organization; requiring that the division deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.0651, F.S.; prohibiting certain costs and attorney fees awarded to plaintiffs in claims for benefits under the motor vehicle no-fault law from being included in insurance rates; amending s. 627.733, F.S.; providing that an owner or registrant of a motor vehicle does not have to comply

with this section if required security is obtained under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law; amending s. 627.736, F.S.; excluding massage and acupuncture from medical benefits that may be reimbursed under the motor vehicle no-fault law; requiring that an insurer give priority to the payment of death benefits under certain conditions; deleting provisions prohibiting the purchase of other motor vehicle coverage; requiring that an insurer repay any benefits covered by the Medicaid program within a specified time; requiring that an insurer provide a claimant an opportunity to revise claims that contain errors; requiring that an insurer create and maintain a log of benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log; requiring that an insurer notify parties in disputes over claims when policy limits are reached; revising the Medicare fee schedules that an insurer may use as a basis for limiting reimbursement of benefits; providing that the Medicare fee schedule in effect on a specific date applies for purposes of limiting such reimbursement; authorizing insurers to apply certain Medicare coding policies and payment methodologies; requiring that an insurer that limits payments based on the statutory fee schedule include a notice in insurance policies at the time of issuance or renewal; deleting obsolete provisions; providing that certain entities exempt from licensure as a

clinic must nonetheless be licensed to receive reimbursement for the provision of personal injury protection benefits; providing exceptions; consolidating provisions relating to unfair or deceptive practices under certain conditions; eliminating a requirement that all parties mutually and expressly agree for the use of electronic transmission of data; creating s. 627.748, F.S.; designating specified provisions as the Florida Motor Vehicle No-Fault Emergency Care Coverage Law; creating s. 627.7481, F.S.; providing purposes; creating s. 627.74811, F.S.; providing legislative intent that provisions, schedules, or procedures are to be given full force and effect regardless of their express inclusion in insurer forms; creating s. 627.7482, F.S.; providing definitions; creating s. 627.7483, F.S.; requiring every owner or registrant of a motor vehicle required to be registered and licensed in this state to maintain specified security; providing exceptions; requiring every nonresident owner or registrant of a motor vehicle that has been physically present within this state for a specified period to maintain security; specifying means by which such security is provided; providing that an owner of a motor vehicle who fails to have such security is not immune to certain liabilities; providing an exemption; creating s. 627.7484, F.S.; providing requirements for filing and maintaining proof of security; providing penalties; creating s. 627.7485, F.S.; requiring that

insurance policies provide emergency care coverage to specified persons; providing limits of coverage; specifying limits for medical, disability, and death benefits; providing restrictions on insurers with respect to provision of required benefits; prohibiting an insurer from requiring the purchase of other motor vehicle coverage as a condition for providing such benefits; prohibiting an insurer from requiring the purchase of property damage liability insurance exceeding a specified amount in conjunction with emergency care coverage insurance; providing that failure to comply with specified availability requirements constitutes an unfair method of competition or an unfair or deceptive act or practice; providing penalties; authorizing an insurer to exclude certain benefits; providing procedure with respect to such exclusions; specifying when benefits are due from an insurer; prohibiting insurers from obtaining liens on recovery of special damages in tort claims for emergency care coverage benefits; prohibiting an insured party from recovering any damages for which emergency care coverage benefits are paid or payable; requiring that benefits received under any workers' compensation law be credited against the benefits provided under the emergency care coverage; providing that benefits under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law are subject to the Medicaid program in specified circumstances; specifying injuries for which an insurer must pay

benefits; providing for notice to insurers; requiring insurers to hold a specified amount of benefits in reserve for a certain time for the payment of providers; requiring that an insurer create and maintain a log of benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log; specifying when benefits are overdue; providing for interest on overdue payments; authorizing an insurer to make certain assertions about a claim; requiring an insurer to provide an itemized specification of each item of a claim which has been reduced, omitted, or denied; providing that payment is not overdue if the insurer has reasonable proof that the insurer is not responsible for the payment; providing for a pro rata distribution of benefits paid and expenses if there are two or more insurers; requiring that an insurer notify parties in disputes over claims when policy limits are reached; providing for tolling the time period in which benefits are required to be paid when the insurer has reasonable belief that fraud has been committed; requiring that the insurer notify the claimant if the claim is being investigated for fraud; providing immunity to persons or entities that report suspected fraud in good faith; providing that an insurer who fails to timely provide benefits violates the insurance code; providing that a person or entity lawfully rendering treatment to an injured person for a bodily injury covered by emergency care coverage may


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charge only a reasonable amount for services and care; providing that the insurer may pay such charges directly to the person or entity lawfully rendering such treatment; providing limits on such charges; providing for determination of reasonableness of charges; providing that payments made by an insurer pursuant to the schedule of maximum charges, or for lesser amounts billed by providers, are considered reasonable; establishing a schedule of maximum charges; specifying that reimbursement under a schedule of maximum charges which is based on Medicare is to be calculated under the applicable Medicare schedule in effect on a specified date each year; authorizing insurers to use all Medicare coding policies and CMS payment methodologies in determining reimbursement under a schedule of maximum charges which is Medicare based; establishing limits on specified emergency services and care; providing conditions under which an insurer or insured is not required to pay a claim or charges; requiring the Department of Health to adopt by rule a list of diagnostic tests deemed not to be medically necessary and to periodically revise the list; providing procedures and requirements with respect to statements of and bills for charges for emergency services and care; requiring that a notice of the insured's rights include a specified statement; requiring that a physician, licensed professional, clinic, or medical institution providing medical services require an

insured person to execute and countersign a disclosure and acknowledgement form; directing the Financial Services Commission to adopt by rule a disclosure and acknowledgment form to be countersigned by claimants upon receipt of medical services; providing procedures and requirements with respect to investigation of claims of improper billing by a physician or other medical provider; prohibiting insurers from systematically downcoding with intent to deny reimbursement; requiring insureds and persons to whom the right to payment for benefits has been assigned to comply with all terms of the policy; providing that compliance with policy terms is a condition precedent to the receipt of benefits; requiring that an employer furnish a sworn statement of an employee's earnings under certain circumstances; requiring that an insured's assignee comply with the terms of the insurance policy; prohibiting an insured from being required to submit to an examination under oath; requiring that all claimants produce and allow for the inspection of all documents requested by the insurer under certain circumstances; providing for insurers to inspect the physical premises of providers seeking payment; requiring that a provider seeking payment furnish to the insurer a written report; authorizing the insurer to petition the court to enter an order permitting discovery of facts under certain circumstances; requiring the insurer to furnish to the injured person a copy of all information; prohibiting

an insured from unreasonably withholding notice to an insurer of the existence of a claim; providing for the examination of the injured person and reports regarding the examination; prohibiting an insurer from withdrawing payment from a treating physician under certain circumstances; providing requirements with respect to a demand letter; providing procedures and requirements with respect to payment of an overdue claim; providing for the tolling of the time period for an action against an insurer; providing that failure to pay valid claims with specified frequency constitutes an unfair or deceptive trade practice; providing penalties; providing circumstances under which an insurer has a cause of action; providing for fraud advisory notice; requiring that all claims related to the same health care provider for the same injured person be brought in one action unless good cause is shown; authorizing the electronic transmission of notices and communications under certain conditions; creating s. 627.7486, F.S.; providing an exemption from tort liability for certain damages in legal actions under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law in certain circumstances; providing for recovery of tort damages in certain circumstances; providing for motions to dismiss action on specified grounds; prohibiting a claim for punitive damages in excess of the coverage policy limits; creating s. 627.7487, F.S.; providing for optional deductibles and

791184

limitations of coverage for emergency care coverage policies; requiring a specified notice to policyholders; creating s. 627.7488, F.S.; requiring the commission to adopt by rule a form for the notification of insureds of their right to receive emergency care coverage benefits; specifying contents of such notice; providing requirements for the mailing or delivery of such notice; creating s. 627.7489, F.S.; providing for mandatory joinder of specified claims; creating s. 627.749, F.S.; providing for an insurer’s right of reimbursement for emergency medical care benefits paid to a person injured by a commercial motor vehicle under specified circumstances; creating s. 627.7491, F.S.; providing for application of the Florida Motor Vehicle No-Fault Emergency Care Coverage Law; providing for requirements for forms and rates for policies issued or renewed on or after a specified date; requiring a specified notice to existing policyholders; amending s. 817.234, F.S.; providing that it is insurance fraud to present a claim for personal injury protection or emergency care coverage benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents relating to licensure as a health care clinic; providing that a licensed health care practitioner who is found guilty of certain insurance fraud loses his or her license and may not receive reimbursement for personal injury protection or emergency care coverage benefits for a specified period; defining the term


791184

"insurer"; conforming provisions; amending ss. 316.065, 316.646, 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032, 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 626.9894, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.737, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234, F.S.; conforming provisions; requiring that the Office of Insurance Regulation perform a data call relating to emergency care coverage and publish the results; prescribing required

224150

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (791184) (with title amendment)

Delete line 2222
and insert:
(13) ATTORNEY FEES.—With respect to any dispute under ss. 627.748-627.7491 between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon the rendition of a judgment or decree by any court in this state, the trial court or, upon appeal the appellate court, shall adjudge or decree a reasonable sum as fees or compensation for attorney fees in favor of the prevailing party, except as

224150

provided in subsections (8) and (12). If awarded, attorney fees or compensation must be included in the judgment or decree rendered in the case.

(14) SECURE ELECTRONIC DATA TRANSFER.—A notice,

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

And the title is amended as follows:

Delete line 4148

and insert:

cause is shown; providing for attorney fees; authorizing the electronic

578696

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (791184)

Delete line 1342
and insert:
464, or a chiropractic physician licensed under chapter 460.

A physician who renders a diagnosis that requires prescribed followup services and care under this sub-subparagraph may not accept a fee for the referral of the insured to a person or entity providing the followup services and care unless the physician rendering the diagnosis discloses in writing to the insured and the insurer that the physician has received a

578696

referral fee, the amount of the referral fee, and the name and business address of the person or entity that provided the referral fee.

527256

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	

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

Senate Amendment (with title amendment)

Delete lines 518 - 541.

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

And the title is amended as follows:

Delete lines 46 - 49

and insert:

s. 627.736, F.S.; excluding massage


104666

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Substitute for Amendment (527256) (with title amendment)

Delete lines 1265 - 1270

and insert:

(8) ATTORNEY ~~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 assignee of an insured's rights and the insurer, upon the rendition of a judgment or decree by any court in this state, the trial court or, upon appeal the appellate court, shall adjudge or decree a reasonable sum as attorney fees

104666

or compensation for attorney fees in favor of the prevailing party ~~the provisions of s. 627.428 shall apply~~, except as provided in subsections (10) and (15). In determining a reasonable sum as attorney fees or compensation for attorney fees for a prevailing insured or assignee of such insured's rights, the court may consider the application of a contingency risk multiplier. If awarded, attorney fees or compensation for attorney fees must be included in the judgment or decree rendered in the case.

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

And the title is amended as follows:

Delete line 79

and insert:

claims when policy limits are reached; revising provisions relating to attorney fees; consolidating

220258

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 1270
and insert:
apply, except as provided in subsections (10) and (15). However, notwithstanding s. 627.428, the attorney fees recovered under s. 627.748-627.7491 shall be calculated without regard to any contingency risk multiplier.

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

220258

Delete line 79

and insert:

claims when policy limits are reached; allowing fees to be calculated without a contingency risk multiplier; consolidating consolidating

760588

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 1265 - 1270
and insert:
(8) ATTORNEY ~~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 assignee of an insured's rights and the insurer, upon the rendition of a judgment or decree by any court in this state, the trial court or, upon appeal the appellate court, shall adjudge or decree a reasonable sum as attorney fees or compensation for attorney fees in favor of the prevailing

760588

party ~~the provisions of s. 627.428 shall apply~~, except as provided in subsections (10) and (15). In determining a reasonable sum as attorney fees or compensation for attorney fees for a prevailing insured or assignee of such insured's rights, the court may consider the application of a contingency risk multiplier. If awarded, attorney fees or compensation for attorney fees must be included in the judgment or decree rendered in the case.

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

And the title is amended as follows:

Delete line 79

and insert:

claims when policy limits are reached; revising provisions relating to attorney fees; consolidating

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

To Bill and Amdt 791184

2-2-12
Meeting Date

Topic Acupuncture

Bill Number SB 1860 *(if applicable)*

Name Pat Mixon

Amendment Barcode 791184 *(if applicable)*

Job Title Governmental Consultant

Address 119 East Park Avenue
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-528-44

E-mail pat@mixonandassociates.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Myself regarding personal health issues

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP INSURANCE

Bill Number SB 1860 *(if applicable)*

Name DAVID A. HART

Amendment Barcode 220258 *(if applicable)*

Job Title EXEC V.P.

Address 136 S. BRONOUGH
Street

Phone 850. 521-1200

TALLAHASSEE, FL 32301
City *State* *Zip*

E-mail dhart@flchamber.com

Speaking: ☑ For ☐ Against ☐ Information

Representing FL CHAMBER

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Bill and Brad

2-2-12
Meeting Date

Topic Acupuncture

Bill Number SB 1860 *(if applicable)*

Name John Cerra

Amendment Barcode 791860 *(if applicable)*

Job Title Governmental Consultant

Address 11441 SW 110 Lane
Street

Phone 786-525-6233

Miami FL
City *State* *Zip*

E-mail

Speaking: ☐ For ☑ Against ☐ Information

Representing Myself, discussing personal health issues.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic Acupuncture

Bill Number SB 1860 *(if applicable)*

Name Juhan Mixon

Amendment Barcode 791869 *(if applicable)*

Job Title Governmental Consultant

Address 119 East Park Avenue
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-528-4441

E-mail juhan@mixonandassociates.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Florida State Oriental Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP AUTO INSURANCE

Bill Number 1860 *(if applicable)*

Name BILL NEWTON

Amendment Barcode 791184 *(if applicable)*

Job Title EXECUTIVE DIRECTOR

Address 3006 W. KENNEDY BLVD STE B *Street*

Phone 813-877-6712

TAMPA *City* FL *State* 33609 *Zip*

E-mail BILLN@FCAN.ORG

Speaking: ☐ For ☒ Against ☐ Information

Representing FLORIDA CONSUMER ACTION NETWORK

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Russel Lazega

Amendment Barcode 527256 *(if applicable)*

Job Title Attorney, Author of Leading Text on Fla. PIP

Address 45 E. Sheridan St.
Street
Dania Beach, FL 33004
City *State* *Zip*

Phone

E-mail

Speaking: ☐ For ☒ Against ☐ Information

Representing Responsive Insurance Company

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Feb 2, 2012
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Kim Driggers

Amendment Barcode 527256 *(if applicable)*

Job Title Lawyer

Address 909 E. Park Ave
Street
Tallahassee, FL 32301
City *State* *Zip*

Phone 850.222.2000

E-mail kdriggers@tallahasseeattorneys.com

Speaking: ☐ For ☒ Against ☐ Information

Amend.

Representing Florida Justice Assn

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP AUTO INSURANCE

Bill Number 1860 *(if applicable)*

Name BILL NEWTON

Amendment Barcode 527256 *(if applicable)*

Job Title EXECUTIVE DIRECTOR

Address 3006 W KENNEDY BLVD STE B
Street
TAMPA, FL 33609
City *State* *Zip*

Phone 813-877-6712

E-mail BILLN@FCAN.ORG

Speaking: ☐ For ☒ Against ☐ Information

Representing FLORIDA CONSUMER ACTION NETWORK

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Feb 2, 2012
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Kim Driggers

Amendment Barcode 527256 *(if applicable)*

Job Title Lawyer

Address 909 E. Park Ave
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850.222.2000

E-mail kdriggers@tallahasseeattorneys.com

Speaking: ☐ For ☒ Against ☐ Information
Amends.

Representing Florida Justice Assn.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic P I P

Bill Number 1860 *(if applicable)*

Name Jeff Morrison DC

Amendment Barcode *(if applicable)*

Job Title Chiropractor

Address 1609 91st St. NW. *Street*

Phone 941-739-2225

City Bradenton State FL Zip 34209

E-mail dr.morrison@verizon.net

Speaking: ☑ For ☐ Against ☐ Information

Representing Fl. Chiropractic Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP Fraud

Bill Number SB 860 *(if applicable)*

Name Chris Connell

Amendment Barcode _____ *(if applicable)*

Job Title Major - Tallahassee Police Dept

Address 234 E. Seventh Ave. *Street*

Phone 850-891-4304

Tallahassee *City* FL *State* 32301 *Zip*

E-mail Chris.Connell@Talgov.com

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida Police Chiefs Assn

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP Bill

Bill Number 1860

Name Kevin Weiss

Amendment Barcode [redacted] *(if applicable)*

Job Title Appellate Attorney

760588 *(if applicable)*

Address 698 North Maitland Ave.
Street

Phone 407-509-1539

Maitland, FL 32751
City *State* *Zip*

E-mail Weiss@weisslegalgroup.com

Speaking: ☐ For ☑ Against ☐ Information

Representing SELF

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP INSURANCE

Bill Number SB 1860 *(if applicable)*

Name DAVID A HART

Amendment Barcode _____ *(if applicable)*

Job Title EXEC. VP

Address 136 S. BRONOUGH
Street

TALLAHASSEE FL 32301
City *State* *Zip*

Phone 850-521-1200

E-mail dhart@flchamber.com

Speaking: ☐ For ☐ Against ☒ Information

Representing FL CHAMBER

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Tammy Perdue

Amendment Barcode *(if applicable)*

Job Title General Counsel

Address 516 N. Adams St *Street*

Phone 850-224-7173

Tallahassee *City* FL *State* 32301 *Zip*

E-mail tperdue@aif.com

Speaking: [redacted] ☐ Against ☑ Information

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/2012
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Robert Heath

Amendment Barcode 220258 *(if applicable)*

Job Title Attorney

Address 423 N. Baylen St
Street
Pensacola FL 32501
City *State* *Zip*

Phone (850) 466-3888

E-mail [redacted] Robert@roberthealthlaw.com

Speaking: ☐ For ☒ Against ☐ Information

Representing Florida Justice Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/2012
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Robert Heath

Amendment Barcode 220258 *(if applicable)*

Job Title attorney

Address 423 N. Baylen St.
Street

Pensacola FL 32501
City *State* *Zip*

Phone (850) 466-3888

E-mail Robert@roberthealthlaw.com

Speaking: ☐ For ☒ Against ☐ Information

Representing Florida Justice Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Gerald Wester

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 101 E College Av
Street

Tall FL
City *State* *Zip*

Phone _____

E-mail Gwester@capcityconsulting.com

Speaking: ☐ For ☐ Against ☒ Information (Lean)

Representing American Insurance Association AIA

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP Bill

Bill Number 1860

Name Kevin Weiss

Amendment Barcode [redacted] *(if applicable)*

Job Title Appellate Attorney

760588 *(if applicable)*

Address 698 North Maitland Ave.
Street

Phone 407-509-1539

Maitland, FL 32751
City *State* *Zip*

E-mail weiss@weisslegalgroup.com

Speaking: ☐ For ☒ Against ☐ Information

Representing GEICO

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this

THE FLORIDA SENATE

APPEARANCE RECORD

2-2-12 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic PIP Bill Number 1860 *(if applicable)*

Name Michael Carlson Amendment Barcode *(if applicable)*

Job Title Executive Director

Address 215 S. Monroe St. Ste. 835 Phone 544 9576

Street

Tallahassee FL 32312 E-mail Michael.Carlson@PIFF.net

City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing Personal Insurance Federation of Florida

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Russel Lazega

Amendment Barcode 527256 *(if applicable)*

Job Title Attorney, Author of Leading Text on Fla. PIP

Address 45 E. Sheridan St.
Street
Dania Beach, FL 33004
City *State* *Zip*

Phone

E-mail

Speaking: ☐ For ☒ Against ☐ Information

Representing Responsive Insurance Company

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP AUTO INSURANCE Bill Number 1860 *(if applicable)*

Name BILL NEWTON Amendment Barcode _____ *(if applicable)*

Job Title EXECUTIVE DIRECTOR

Address 3006 W KENNEDY BLVD STE B *Street*
TAMPA, FL 33609 *City State Zip*

Phone 813-877-6712

E-mail BILL@FCAN.ORG

Speaking: [X] For [ ] Against [ ] Information

Representing FLORIDA CONSUMER ACTION NETWORK

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Janet Mabry

Amendment Barcode *(if applicable)*

Job Title Consultant

Address 2866 Bay Heather Cir
Street

Phone 850-934-1629

Gulf Breeze FL. 32563
City *State* *Zip*

E-mail MabryJF@cs.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida State Massage Therapy Assn.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP

Bill Number SB1860 *(if applicable)*

Name Jay Ryan

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 2045 S. Monroe St
Street

_____
City *State* *Zip*

Phone 681-6710

E-mail jay@blenklaw.com

Speaking: ☐ For ☐ Against ☒ Information

Representing MetLife & Nationwide

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Cheryl Amundsen

Amendment Barcode _____ *(if applicable)*

Job Title Concerned Citizen

Address _____ *Street*

Phone _____

_____ *City* *State* *Zip*

E-mail _____

Speaking: ☐ For ☐ Against ☑ ~~Information~~

Representing Put the Brakes on Accident Fraud Coaliti

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ ~~No~~

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP

Bill Number SB 1860 *(if applicable)*

Name Dr. Chip Smith

Amendment Barcode *(if applicable)*

Job Title Chiropractor

Address 555 Ave L
Street

Phone 863-293-4249

Winter Haven FL 33881
City *State* *Zip*

E-mail DrHG.Smith@Verizon.net

Speaking: ☑ For ☐ Against ☐ Information

Representing Fla Chiropractic Assoc

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic PIP

Bill Number ~~1080~~ 1580
(if applicable)

Name Kerri Rayborn

Amendment Barcode _____
(if applicable)

Job Title _____

Address _____
Street

Phone 850 524 2394

_____
City *~~State~~* *Zip*

E-mail _____

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida Sheriff's Assoc.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

_____
Meeting Date

Topic _____ Bill Number 1860 *(if applicable)*

Name DONOVAN BROWN Amendment Barcode _____ *(if applicable)*

Job Title COUNSEL, STATE GOVERNMENT RELATIONS

Address _____ Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing PROPERTY & CASUALTY INSURERS ASSOCIATION OF AMERICA

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2 Feb 12
Meeting Date

Topic PIP

Bill Number 1860 *(if applicable)*

Name Rebecca O'Hara

Amendment Barcode *(if applicable)*

Job Title VP Govt Affairs

Address 113 E College Ave
Street

Phone 339 6211

Tallahassee FL 32301
City *State* *Zip*

E-mail rohara@flmedical.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Fla Medical Ass'n

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

02.02.12
Date

1860
Bill Number

221450
Barcode

Name William Large

Phone 8502220170

Address 210 S. Monroe Street
Street

E-mail william@pjustice.org

Tallahassee FL 32301
City *State* *Zip*

Job Title President

Speaking: ☐ For ☐ Against ☒ Information

Appearing at request of Chair ☐

Subject motor vehicle personal injury protection insurance

Representing Florida Justice Reform Institute

Lobbyist registered with Legislature: ☒ Yes ☐ No

Pursuant to s. 11.061, *Florida Statutes*, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

If designated employee: Time: from_____ ___.m. to _____ ___.m.

S-001 (04/14/10)

THE FLORIDA SENATE

APPEARANCE RECORD

2/2/12 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic PIP Bill Number 1860 *(if applicable)*

Name Pam Langford Amendment Barcode *(if applicable)*

Job Title H.E.A.L.S. of the South

Address *Street* Phone

City *State* *Zip* E-mail

Speaking: ☐ For ☐ Against ☒ Information

Representing Put the Brakes on Accident Fraud Coaliti

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP BILL

Bill Number 1860 *(if applicable)*

Name RUTLEDGE BRADFORD

Amendment Barcode *(if applicable)*

Job Title ATTORNEY

Address 5210 S. ORANGE AVE. *Street*

Phone (407) 926-3710

ORLANDO, FL 32809 *City State Zip*

E-mail rutledge1C bradfordlaw.com

Speaking: ☑ For ☐ Against ☐ Information

Representing SELF

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/2012
Meeting Date

Topic _____ Bill Number SB 1860 *(if applicable)*

Name Mark Delegal Amendment Barcode _____ *(if applicable)*

Job Title Retained Counsel

Address 215 S. Monroe Street #200 Phone 850 222-3533
Street

Tallahassee FL 32301 E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing State Farm Mutual Automobile Ins. Co.

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP

Bill Number SB1860 *(if applicable)*

Name Russel Lazega

Amendment Barcode _____ *(if applicable)*

Job Title Attorney, Author of leading legal text on PIP

Address 45 E. Sheridan St.
Street
Dania Beach FL 33004
City *State* *Zip*

Phone 754-263-4252

E-mail Russ@Lazegalaw.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Responsive Auto Insurance Company

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic PIP Bill

Bill Number 1860

Name Kevin Weiss

Amendment Barcode [redacted] 760588 *(if applicable)*

Job Title Attorney

Address 698 N. Maitland Avenue
Street
Maitland, FL. 32751
City *State* *Zip*

Phone 407-599-9036

E-mail weiss@weisslegalgroup.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

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 1860
INTRODUCER:	Banking and Insurance Committee and Senator Negron
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	February 02, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Fav/CS**
2.			BC	
3.				
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:

Senate Bill 1860 amends the Florida Motor Vehicle No-Fault Law. The bill primarily amends the laws governing Personal Injury Protection (PIP) medical benefits under the No-Fault law and laws related to motor-vehicle insurance fraud. The major changes enacted by the bill are as follows:

PIP Medical Benefits – Eliminates PIP medical benefit reimbursement for massage as defined in s. 480.033, F.S., and acupuncture as defined in s. 457.102, F.S.

Payment of PIP Benefits – Makes the following changes regarding payment of PIP benefits:

- Insurers must give priority to the payment of the $5,000 death benefit over other PIP benefits.
- Expands the requirement to reserve $5,000 of PIP benefits to physicians or dentists providing emergency treatment to include hospitals.
- Insurers must repay the full amount of benefits paid by the Medicaid program within 30 days after receipt of notice.
- An insurer that rejects a claim or pays only a portion of a claim due to an alleged error in the claim must include with the rejection or partial payment an itemized specification or

explanation of benefits of the specified error. The claimant then has 15 days to submit a revised claim.
- Insurers must maintain a log of PIP benefits paid by the insurer to each insured. The insurer must provide the payment log within 30 days after receiving a request for the log from the insured or an assignee.
- If there is a dispute between an insurer and an insured or assignee and policy limits are reached, the insurer must notify the insured or assignee that policy limits have been reached within 15 days.

PIP Medical Fee Schedule – Makes the following changes regarding the content and application of the PIP medical fee schedule:
- Specifies that the Medicare fee schedule in effect on January 1 will apply to all medical care and supplies rendered in that calendar year.
- Effective July 1, 2012, an insurer may only limit reimbursement pursuant to the PIP fee schedule if the insurer provides notice at the issuance or renewal of the auto insurance policy that the insurer will provide reimbursement pursuant to the fee schedule.
- Authorizes insurers to use Medicare coding policies and payment methodologies so long as they do not constitute a utilization limit.
- Specifies that the Medicare Part B fee schedule applies to services, supplies and care provided by ambulatory surgical centers and clinical laboratories under the PIP fee schedule.
- Specifies that durable medical equipment is reimbursed at 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B.

Mandatory Clinic Licensure; Exceptions – All entities providing health care services must be licensed clinics in order to receive PIP reimbursement except for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (ch. 458, F.S. and ch. 459, F.S.), licensed dentists, and licensed chiropractors or jointly owned by such practitioners and specified family members.

Crash Reports – Long form crash reports must be completed and submitted to the DFS for all crashes involving a passenger other than a driver or when any party involved complains of pain or discomfort. Both the long-form and short-form reports are modified to identify the vehicle each party was in and whether he or she was a driver or passenger. Telephone numbers will no longer be included in such reports unless a party is charged with a criminal traffic offense. The bill also authorizes the law enforcement officer who investigated a crash to testify at trial or provide an affidavit that confirms or supplements information in a completed crash report.

Clinic Licensure Insurance Fraud – Defines as a false and fraudulent insurance claim under s. 817.234, F.S., presenting PIP claims to an insurer that a person knows are made on behalf of a payee that knowingly submitted a false, misleading, or fraudulent document when applying for clinic licensure, a clinic licensure exemption, or demonstrating compliance with the Health Care Clinic Law. Such acts are subject to investigation by the Division of Insurance Fraud. The AHCA clinic licensure application and exemption forms will provide notice of criminal liability for committing such acts.

Health Care Practitioner License Suspension – A licensed health care practitioner found guilty of insurance fraud under s. 817.234, F.S., will have his or her licensed revoked for 5 years and may not receive PIP reimbursement for 10 years.

Electronic Records – Permits electronic transmission of all notices, documents, communications and transmissions required or authorized under the No-Fault law. Deletes the requirement that electronic transmission may only occur if all parties expressly agree. Effective December 1, 2012.

Auto Insurance Fraud Direct Support Organization – Creates a non-profit direct support organization designed to receive money from private persons that will fund state agencies, state attorneys' offices, and the statewide prosecutor for the purposes of preventing, investigating, and prosecuting motor vehicle insurance fraud. The board of directors consists of the CFO, who serves as the chair, and eight appointed members.

PIP Data Call – Requires the Office of Insurance Regulation to perform a comprehensive PIP data call and publish the results by January 1, 2015. The data call will analyze the impact of the act's reforms on the PIP insurance market.

The bill is effective July 1, 2012, except as otherwise expressly provided.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.9905, 400.991, 626.989, 626.9894, 627.736, and 817.234.

This bill creates the following section of the Florida Statutes: 626.9895.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law[1], 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.[2] 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.[3] 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.[4] The personal injury protection must provide a minimum

[1] Sections 627.730-627.7405, F.S.
[2] See s. 627.731, F.S.
[3] Section 627.737, F.S.
[4] See sections 324.022, F.S. and 627.733, F.S.

benefit of $10,000 for bodily injury to any one person.[5] Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses,[6] 60 percent of loss of income,[7] 100 percent of replacement services,[8] 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.[9]

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.[10] 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 provides 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; or
- Licensed health care clinics that meet specified criteria.[11]

Medical Fee Limits for PIP Reimbursement

Section 627.736(5), F.S., 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; and
- 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.[12] Also, the insurer must reimburse any health care provider rendering services

[5] Section 627.736(1), F.S.
[6] Section 627.736(1)(a), F.S.
[7] Section 627.736(1)(b), F.S.
[8] Id.
[9] Section 627.736(1)(c), F.S.
[10] Chapter 2007-324, L.O.F.
[11] See sub-subparagraphs 1-5 of s. 627.736(1)(a), F.S.
[12] Section 627.736(5)(a)4., F.S.

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 copayment) or for amounts that exceed maximum policy limits.[13]

Motor Vehicle Insurance Rates

Motor vehicle insurance rates have increased dramatically since the 2008 re-enactment of the No-Fault law. The Office of Insurance Regulation provided committee staff a summary of the cumulative motor vehicle rate increases implemented from January 1, 2009, to February 1, 2012, by the five insurance carriers with the largest market share in the Florida marketplace.[14]

Coverage	State Farm Mutual	GEICO General[15]	Progressive American[16]	Progressive Select[17]	Allstate Insurance
PIP	**49.7%**	**87.6%**	**62.8%**	**50.2%**	**35.1%**
PD	40.0%	-0.9%	-3.9%	5.9%	29.6%
BI	40.0%	49.0%	33.2%	33.9%	46.3%
UM	52.4%	-3.2%	50.2%	75.4%	-7.4%
Med Pay	-3.8%	5.9%	7.9%	19.5%	23.1%
Collision	-15.9%	-22.1%	-20.7	-14.8%	-24.7%
Comp.	-7.2%	-18.0%	-28.2%	-21.7%	-26.3%
TOTAL	**26.0%**	**19.6%**	**19.2%**	**19.2%**	**11.5%**

These premium increases have occurred despite data obtained from the Department of Highway Safety and Motor Vehicles showing decreases in:

- The number of licensed drivers in Florida (15,579,603 in 2008 to 15,553,387 in 2010).
- The frequency of auto crashes in Florida (1.56 crashes per 100 licensed drivers in 2008 to 1.52 crashes per licensed driver in 2010).
- The number of crash-related injuries in Florida (199,658 in 2008 to 195,104 in 2010.

Though the number of drivers, crashes, and injuries decreased from 2008 to 2010, the direct incurred losses of insurers dramatically increased from approximately $1.475 billion in 2008 to approximately $2.298 billion in 2010, an increase of approximately 55.8 percent.

The foregoing rate increases led the Office of Insurance Regulation (OIR) to promulgate a Personal Injury Protection data call[18] and issue a report on its findings in April 2011.[19] The OIR

[13] Section 627.736(5)(a)5., F.S.
[14] Data supplied by the Office of Insurance Regulation, based on data submitted in the Rate Collection System as of February 1, 2012.
[15] Includes two pending filings as of February 1, 2012.
[16] Includes one pending filing as of February 1, 2012.
[17] Includes one pending filing as of February 1, 2012
[18] Thirty-one companies participated in the data call, constituting approximately 80 percent of the private passenger No-Fault premium market in Florida.
[19] OIR Report on Review of the 2011 Personal Injury Protection Data Call (April 11, 2011).

report found large increases in medical provider charges, which increased from approximately $10,000 per claim in 2007 to $12,000 per claim in 2010.[20] The average number of procedures per claim greatly increased from less than 70 per claim in 2007 to over 100 per claim in 2010.[21] The average provider charge per procedure showed a slight decrease during 2008-2010, which is unsurprising given the enactment of the PIP medical fee schedule. The OIR data call indicates that the large loss increases insurers have incurred from 2008-2010 are due largely to sizeable increases in the number of treatments provided per PIP claim.

In December 2011, the Insurance Consumer Advocate issued a Report on Florida Motor Vehicle No-Fault Insurance. The report was based largely on information gathered through a Personal Injury Protection Working Group (Working Group) convened in August 2011 by the Consumer Advocate at the request of the Chief Financial Officer to research and analyze the No-Fault system and why losses and premiums are rapidly increasing.

The Consumer Advocate's report found rapid growth in the number of procedures billed from 2005 to 2010. The largest increases were found for "Massage, 15 minutes" and "Therapeutic Exercise, 15 minutes" which each increased by approximately 2.6 million units from 2005 to 2010.[22] Specifically, "Massage, 15 minutes" increased from approximately 1.42 million units in 2005 to approximately 4.05 million units in 2010, while therapeutic exercise increased from approximately 713,000 units in 2005 to 3.36 million units in 2010. These two procedures are now the two most commonly billed procedures in the PIP system.

The Consumer Advocate's report also presented data on increases in the average charge per claimant by provider. Average charges by massage therapists saw the greatest increase, increasing from $2,887 in 2005 to $4,350 in 2010.[23] The second largest increase was by acupuncturists, whose average charge increased from $2,754 in 2005 to $3,674 in 2010.[24] In contrast, the average charge by an orthopedic surgeon only increased $126 from 2005-2010, billing on average the comparatively smaller figure of $2,810 in 2010.[25] As of 2010, massage therapists and acupuncturists issue the largest average charges of any medical provider that bill within the PIP system.[26]

Motor Vehicle Insurance Fraud

Over the past 5 years, 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)[27] nearly doubled from fiscal year 2008/2009 (776)[28] to fiscal year 2010/2011 (1,416).[29] The Division is also reporting sizeable increases in the overall number of PIP fraud

[20] See id. at pg. 13
[21] See id.
[22] Office of the Insurance Consumer Advocate Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection, pg. 23 (December 2011).
[23] See id. at pg. 21.
[24] See id.
[25] See id.
[26] See id.
[27] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[28] Florida Department of Financial Services Division of Insurance Fraud Statistical Report: Fiscal Year 2008/209, pg. 12.
[29] Florida Department of Financial Services Division of Insurance Fraud Annual Report: Fiscal Year 2010/2011, pg. 30.

referrals, which have increased from 3,151 during fiscal year 2007/2008[30] to 6,699 in fiscal year 2010/2011.[31] Florida led the nation in staged motor vehicle accident "questionable claims"[32] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[33]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee issued 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 3 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 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 in obtaining exemptions from the Health Care Clinic Law.
- 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.
- 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.

[30] See fn. 25.
[31] See fn. 26.
[32] See fn. 19 at pg. 29. 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.
[33] 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

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.*,[34] 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 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 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 officer 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,

[34] *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

including a mobile clinic and a portable equipment provider."[35] 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.

An applicant[36] for clinic licensure must submit to and pass a level 2 background screening pursuant to s. 435.04, F.S., 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). 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.[37] 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.[38] Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within 5 months after the end of the fiscal year.[39]

III. Effect of Proposed Changes:

Traffic Crash Reports

Section 1. Amends s. 316.066, F.S., to require that Long-Form crash reports be completed and submitted to the DFS for all crashes involving a passenger or when any party complains of pain or discomfort. All crash reports are modified to identify the vehicle each driver or passenger was in. Telephone numbers will not be included in such reports unless a party is charged with a criminal traffic offense. The bill also authorizes the law enforcement officer who investigated the crash to testify at trial or provide an affidavit that confirms or supplements information in a completed crash report.

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[35] Section 400.9905(4), F.S.
[36] An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.
[37] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla. 2005)
[38] *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).
[39] *See* ss. 11.45, 215.981, F.S.

Section 10. Technical conforming change to s. 316.065, F.S., necessitated by the substantive amendment to s. 316.066, F.S.

Health Care Clinic Related Insurance Fraud

Submitting PIP Claims on Behalf of Fraudulent Clinics

Section 9. Amends s. 817.234(1)(a), F.S., to define as insurance fraud presenting a claim for PIP benefits on behalf of an entity while knowing that the entity knowingly submitted a false, misleading, or fraudulent application or document when applying for health care clinic licensure, licensure exemption, or demonstrating compliance with the Health Care Clinic Law. Insurance fraud under s. 817.234, F.S., is a felony offense and fraud related to motor vehicle insurance is also subject to monetary civil penalties.

Notice of Health Care Clinic Licensure Insurance Fraud

Section 3. Amends s. 400.991, F.S., to require all AHCA forms for clinic licensure or exemption to include a notice of criminal liability. The notice states that submitting a false, misleading, or fraudulent document when applying for clinic licensure, clinic licensure exemption, or demonstrating compliance with the Health Care Clinic Law (part X, ch. 400, F.S.), with the intent to provide services or seek reimbursement under the No-Fault law is a fraudulent insurance act subject to investigation by the Division of Insurance Fraud pursuant to s. 626.989, F.S. The notice also states that presenting a claim for PIP benefits knowing that the payee knowingly submitted a fraudulent clinic application or document commits insurance fraud pursuant to s. 817.234, F.S.

Clinic-Related Insurance Fraud Subject to Investigation by Division of Insurance Fraud

Section 4. Amends s. 626.989, F.S., which defines acts that are subject to investigation by the Division of Insurance Fraud as a "fraudulent insurance act." Expansion of the definition is intended to expand the ability of the Division of Insurance Fraud to investigate health care clinic fraud. A "fraudulent insurance act" is:

- The knowing submission of a false, misleading, or fraudulent application or document when applying for health care clinic licensure, a licensure exemption, or demonstrating compliance with the Health Care Clinic Law with the intent to use the license, exemption, or compliance to provide services or seek PIP reimbursement; or
- Presenting a claim for payment or benefits under a PIP insurance policy while knowing the payee knowingly submitted a false, misleading, or fraudulent application or document when applying for a clinic license, exemption, or demonstrating compliance with the Health Care Clinic Law.

Clinic Licensure Required to Receive PIP Reimbursement

Section 2. Amends s. 400.9905, F.S., to require that all entities providing health care services be licensed clinics in order to receive PIP reimbursement except for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (ch. 458,

F.S. and ch. 459, F.S.), licensed dentists, and licensed chiropractors or jointly owned by such practitioners and specified family members.

Motor Vehicle Fraud Direct Support Organization

Section 5. Amends s. 626.9894, F.S., to specify that the balance of monies deposited in the Insurance Regulatory Trust Fund from the DSO at the end of a fiscal year may be used to fund the Division of Insurance Fraud. The DFS may also request the appropriation of such funds for insurance anti-fraud purposes.

Section 6. Creates s. 626.9895, F.S., which establishes a non-profit direct support organization (DSO) designed to receive money from private persons and entities for the purposes of preventing, investigating, and prosecuting motor vehicle insurance fraud. The DSO is authorized to conduct programs and activities, raise money and invest such monies, and make grants and expenditures that directly or indirectly benefit specified governmental entities to exclusively advance the DSO's purposes.

Grants and expenditures made by the DSO may fund the salaries and benefits of motor vehicle insurance fraud investigators, prosecutors, and support personnel. Such monies and expenditures cannot interfere with prosecutorial independence or create conflicts of interest which threaten the success of prosecutions, nor may they be used for lobbying. Contributions from insurers shall be allowed as an appropriate business expense for regulatory purposes. The DSO is subject to an annual financial audit pursuant to s. 215.981, F.S.

The DSO is governed by an eleven member board of directors, made up as follows:

- The Chief Financial Officer (or designee) who serves as chair.
- Two state attorneys. The CFO and Attorney General each have one appointment.
- Two representatives of motor vehicle insurers appointed by the CFO.
- Two representatives of local law enforcement agencies. The CFO and Attorney General each have one appointment.
- Two representatives of health care providers who regularly make PIP claims. The President of the Senate and Speaker of the House of Representatives each has one appointment.
- A private attorney with experience representing PIP claimants, appointed by the President of the Senate.
- A private attorney with experience representing PIP insurers, appointed by the Speaker of the House of Representatives.

The DSO will operate under a written contract with the Division of Insurance Fraud (DIF). The Division will have approval authority of the DSO's articles of incorporation and bylaws. The DSO must submit an annual budget to the division for its approval. The DSO will also be required to obtain an annual certification from the division that it is complying with the terms of the contract and operating in accordance with the DSO's purposes. The DFS may authorize the DSO to use DIF facilities without charge.

Personal Injury Protection Benefits

Section 7. Amends s. 627.736, F.S., regarding Personal Injury Protection (PIP) No-Fault insurance in the following ways:

PIP Required Benefits [s. 627.736(1), F.S.]

Under current law, subsection (1) of s. 627.736, F.S., details the required personal injury protection benefits, which must include at least $10,000 in medical, disability, and death benefits (the latter of which can be up to $5,000 of the total $10,000 benefit). The bill amends this subsection in the following ways:

Massage and Acupuncture Not Reimbursable – Eliminates PIP medical benefit reimbursement for massage as defined in s. 480.033, F.S., and acupuncture as defined in s. 457.102, F.S.

Death Benefits – Insurers must give priority to the payment of the $5,000 death benefit over other PIP benefits.

Payment of Benefits [s. 627.736(4), F.S.]

Under current law, subsection (4) of s. 627.736(4), F.S., contains requirements related to the payment of No-Fault benefits that insurers and claimants must comply with. Paragraph (b) of this subsection requires insurers to pay personal injury protection benefits within 30 days after receiving written notice of a covered loss. The bill makes the following changes related to the payment of benefits:

Reimbursement to Medicaid – Insurers must repay the full amount of benefits paid by the Medicaid program within 30 days after receipt of notice.

Claims Rejected Due to Claimant Errors – An insurer that rejects a claim or pays only a portion of a claim due to an alleged error in the claim must include with the rejection or partial payment an itemized specification or explanation of benefits of the specified error. The claimant then has 15 days to submit a revised claim and may do so without waiving other legal remedies for payment.

Reservation of PIP Benefits – Expands the requirement to reserve $5,000 of PIP benefits to physicians or dentists providing emergency treatment to include hospitals.

Log of PIP Benefits Provided – Requires insurers to maintain a log of PIP benefits paid by the insurer to each insured. The insurer must provide a copy of the payment log within 30 days after receiving a request for the log from the insured or an assignee.

Medical Fee Schedule [s. 627.736(5)(a), F.S.]

The bill enacts the following changes to the PIP medical fee schedule:

Ambulatory Surgical Centers and Clinical Laboratories – Specifies that the Medicare Part B fee schedule applies to services, supplies and care provided ambulatory surgical centers and clinical laboratories under the PIP fee schedule.

Durable Medical Equipment – Specifies that durable medical equipment is reimbursed at 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B.

Annual Update – Specifies that the Medicare fee schedule in effect on January 1 will apply to all medical care and supplies rendered in that calendar year. The annual update remains subject to the prohibition against reducing reimbursement rates below those contained in the 2007 Medicare Part B schedule.

Medicare Coding Policies and Payment Methodologies – Authorizes insurers to use Medicare coding policies and payment methodologies so long as they do not constitute utilization limits.

Notice of Fee Schedule – Effective July 1, 2012, an insurer may only limit reimbursement pursuant to the PIP fee schedule if the insurer provides notice at the issuance or renewal of the auto insurance policy that the insurer will provide reimbursement pursuant to the fee schedule.

Patient Disclosure [s. 627.736(5)(e), F.S.]

At the initial treatment of an insured, each medical provider must require each injured person to execute a disclosure and acknowledgment form at the initiation of treatment. The executed disclosure attests that the medical services were actually performed. Current law exempts from this requirement services billed by a provider for emergency services, emergency services and care rendered in a hospital emergency department, or for transport and treatment rendered by a licensed ambulance provider. The bill deletes the exemption for "services billed by a provider for emergency services" from the requirement that providers must execute the disclosure and acknowledgement form.

Clinic Licensure Required to Receive PIP Reimbursement [s. 627.736(5)(h), F.S.]

The bill requires all entities providing health care services to be licensed clinics in order to receive PIP reimbursement. The bill provides exemptions for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (ch. 458, F.S. and ch. 459, F.S.), licensed dentists, or licensed chiropractors or jointly owned by such practitioners and specified family members.

Notice that PIP Benefits are Exhausted [s. 627.736(6), F.S.]

If there is a dispute between an insurer and an insured or assignee and policy limits are reached, the insurer must notify the insured or assignee that policy limits have been reached within 15 days of the exhaustion of benefits.

Offer of Judgment Statute Applied to No-Fault Disputes [s. 627.736(8), F.S.]

Applies the offer of judgment statute in s. 768.79, F.S., to PIP disputes. The offer of judgment statute allows a defendant to recover attorney's fees and costs from the plaintiff if the defendant makes an offer to the plaintiff and the plaintiff's ultimate recovery is either $0 or 25 percent less than the defendant's offer. Plaintiffs may make a similar demand for judgment that requires the defendant to pay reasonable fees and costs if the plaintiff recovers a judgment that is 25 percent or more than the amount demanded. However, s. 627.428, F.S., already requires an insurer defendant to pay reasonable costs to a plaintiff upon a judgment or confession of judgment in favor of the plaintiff.

Electronic Records [s. 627.736(16), F.S.]

Section 8. Effective December 1, 2012, deletes that the requirement that electronic transmission of records may only occur if all parties expressly agree. The bill will allow electronic transmission of all notices, documents, communications and transmissions required or authorized under the No-Fault law.

Office of Insurance Regulation Data Call

Section 11. The bill requires the Office of Insurance Regulation to perform a comprehensive PIP data call and publish the results by January 1, 2015. The data call is intended to evaluate market conditions relating to the No-Fault law and measure the effects of this act.

Severability Clause

Section 12. Provides that if any provision of the act is held invalid, the provisions of the act are severable.

Effective Date

Section 13. The act is effective July 1, 2012, except as otherwise provided.

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:

Senate Bill 1860 is intended to reduce No-Fault motor vehicle insurance premiums by removing cost drivers related to certain medical treatments and fraud. Proponents of the bill assert that eliminating reimbursement for massage and acupuncture will reduce losses incurred by insurers and result in corresponding lower premiums for consumers. Providers who bill for massage and acupuncture within the PIP system will experience a negative economic impact.

Health care providers required to obtain clinic licensure to receive PIP reimbursement will be subject to additional costs. Entities obtaining clinic licensure or renewing clinic licensure must pay a $2,000 licensure fee. The Agency for Health Care Administration estimates that new applicants will incur approximately $5,000 in expenses associated with preparing the licensure application, an estimate that is inclusive of the licensure fee. Proponents of this requirement assert that it will help reduce PIP fraud.

The clarifications to the PIP fee schedule are designed to reduce litigation that arises due to disputes over the proper fee amount to be paid under the schedule. Proponents of the allowing insurers to use Medicare coding policies and methodologies assert that their use will result in additional savings. Representatives of some medical providers and plaintiff's attorneys have argued that allowing the use of these coding policies and methodologies incorporates utilization limits into the fee schedule. However, the bill expressly prohibits their use if they constitute a utilization limit.

C. Government Sector Impact:

Representatives from the OIR indicate that the legislation will present a significant resource challenge as the OIR expects significant numbers of auto policy contract changes to be filed to comply with various provisions of the bill. The OIR also anticipates committing significant staff resources to conduct the data call required by the bill.

Representatives from the Division of Insurance Fraud and the Agency for Health Care Administration contend that requiring medical providers to obtain clinic licensure (with exceptions) will increase the ability of agency and division personnel to discover and track clinics engaging in insurance fraud.

The Department of Financial Services also contends that the creation of a direct support organization dedicated to motor vehicle insurance fraud will increase the resources of the Division of Insurance Fraud and other law enforcement agencies to prevent, investigate, and prosecute such fraud. The Direct Service Organization is authorized to use the monies it raises to fund insurance fraud investigators, prosecutors, and support personnel. Proponents of this provision assert this will increase the number of successful

prosecutions for motor vehicle insurance fraud in the state. Concerns have been raised that using private funds to fund these provisions may create conflicts of interest in criminal prosecutions, however, the bill expressly prohibits grants and expenditures that interfere with prosecutorial independence or create conflicts of interest that threaten the success of prosecutions.

The Agency for Health Care Administration (AHCA) estimates that 250 health care providers will obtain health care clinic licensure in Fiscal Year (FY) 2012-2013 to comply with the requirement that health care providers (with exceptions) obtain clinic licensure in order to receive PIP reimbursement. An estimated 50 new licenses are anticipated for FY 2013-2014, while in FY 2014-2015 an estimated 250 new licenses and license renewals will be attributable to the bill. A $2,000 fee is charged to entities obtaining a new or renewal clinic license. AHCA estimates two additional staff will be required (a field surveyor and a licensure analyst) to license the additional clinics. Overall, AHCA anticipates a net gain to the Health Care Trust Fund of $374,481 in FY 2012-2013, a loss of $18,223 in FY 2013-2014, and a gain of $381,777 in FY 2014-2015.

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 Banking and Insurance on February 2, 2012:

Deletes from the bill a provision that would have prohibited insurance companies from including within their rates amounts paid to prevailing plaintiffs for attorney fees and costs.

B. Amendments:

None.

By Senator Negron

28-00905-12 20121860__

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising the conditions for completing the long-form traffic crash report; revising the information contained in the long-form and the short-form reports; limiting the inclusion of telephone numbers in crash reports; authorizing an investigating officer to testify at trial or provide an affidavit regarding a crash; amending s. 400.9905, F.S.; providing that certain entities exempt from licensure as a health care clinic must nonetheless be licensed in order to receive reimbursement for the provision of personal injury protection benefits; amending s. 400.991, F.S.; requiring that an application for licensure, or exemption from licensure, as a health care clinic include a statement regarding insurance fraud; amending s. 626.989, F.S.; providing that knowingly submitting false, misleading, or fraudulent documents relating to licensure as a health care clinic, or submitting a claim for personal injury protection relating to clinic licensure documents, is a fraudulent insurance act under certain conditions; amending s. 626.9894, F.S.; conforming provisions to changes made by act; creating s. 626.9895, F.S.; providing definitions; authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and

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preventing motor vehicle insurance fraud; providing requirements for, and duties of, the organization; requiring that the organization operate pursuant to a contract with the division; providing for the requirements of the contract; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; requiring that the department adopt rules relating to procedures for the organization's governance and relating to conditions for the use of the division's property or facilities; authorizing contributions from insurers; authorizing any moneys received by the organization to be held in a separate depository account in the name of the organization; requiring that the division deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.0651, F.S.; prohibiting attorney fees awarded to plaintiffs in claims for benefits under the motor vehicle no-fault law from being included in insurance rates; amending s. 627.736, F.S.; excluding massage and acupuncture from medical benefits that may be reimbursed under the motor vehicle no-fault law; requiring that an insurer give priority to the payment of death benefits under certain conditions; requiring that an insurer repay any benefits covered by the Medicaid program; requiring that an insurer provide a claimant an opportunity to revise claims that contain errors; including hospitals within a requirement for insurers to reserve a portion of personal injury

protection benefits; requiring that an insurer create and maintain a log of personal injury protection benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log; revising the Medicare fee schedules that an insurer may use as a basis for limiting reimbursement of personal injury protection benefits; providing that the Medicare fee schedule in effect on a specific date applies for purposes of limiting such reimbursement; authorizing insurers to apply certain Medicare coding policies and payment methodologies; requiring that an insurer that limits payments based on the statutory fee schedule include a notice in insurance policies at the time of issuance or renewal; deleting obsolete provisions; providing that certain entities exempt from licensure as a clinic must nonetheless be licensed to receive reimbursement for the provision of personal injury protection benefits; providing exceptions; requiring that an insurer notify parties in disputes over personal injury protection claims when policy limits are reached; consolidating provisions relating to unfair or deceptive practices under certain conditions; eliminating a requirement that all parties mutually and expressly agree for the use of electronic transmission of data; amending s. 817.234, F.S.; providing that it is insurance fraud to present a claim for personal injury protection benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents

relating to licensure as a health care clinic; providing that a licensed health care practitioner guilty of certain insurance fraud loses his or her license and may not receive personal injury protection benefits for a specified period; defining the term "insurer"; amending s. 316.065, F.S.; conforming a cross-reference; requiring that the Office of Insurance Regulation perform a data call relating to personal injury protection; prescribing required elements of the data call; providing for severability; providing effective dates.

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

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 that:

1. Resulted in death, ~~or~~ personal injury, or any complaint of pain or discomfort by any of the parties or passengers involved in the crash;~~.~~

2. Involved one or more passengers in any vehicle involved in the crash, other than the driver of the vehicle; or

3.~~2.~~ Involved a violation of s. 316.061(1) or s. 316.193.

(b) In any ~~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 driver exchange-of-information form to be completed by each party involved in the crash. The agency that employs the law enforcement officer who prepares the short-form crash report shall maintain the report.

(c) The long-form and the short-form reports ~~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, including all drivers and passengers, with each party clearly identified as a driver or passenger and the vehicle that he or she occupied.

4. The names and addresses of witnesses.

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

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

Except for a crash in which a party is charged with a criminal traffic offense, a long-form or short-form crash report may not include the telephone number of a party involved in the crash.

(d) ~~(c)~~ Each party to the crash must provide the law enforcement officer with proof of insurance, which must be documented in the crash report. If a law enforcement officer submits a report on the crash, 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, within 24 hours after the crash, the person provides the law enforcement agency with~~, 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 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. The entity receiving the report may require witnesses of the crash to render reports and may require the ~~any~~ driver of a vehicle involved in a crash of which a written report must be made to file supplemental written reports if the original report is deemed insufficient by the receiving entity.

(f) The law enforcement officer who investigates a crash may testify at trial, provide a deposition for use at trial, or provide a signed affidavit to confirm or supplement information included in the long-form or short-form crash report.

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

Section 2. Subsection (4) of section 400.9905, Florida Statutes, is amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity where ~~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. As used in ~~For purposes of~~ this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; ~~or~~ entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses ~~granted~~ under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses ~~granted~~ under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric

hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses ~~granted~~ under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses ~~granted~~ under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485,

subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees at least ~~not less than~~ two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is ~~which are~~ wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or

sibling of a licensed health care practitioner if~~, so long as~~ one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) which ~~that~~ provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic or prosthetic clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

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

Section 3. Subsection (6) is added to section 400.991, Florida Statutes, to read:

400.991 License requirements; background screenings; prohibitions.—

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

INSURANCE FRAUD NOTICE.—A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-

Fault Law, commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for personal injury protection benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in s. 817.234, Florida Statutes.

Section 4. Subsection (1) of section 626.989, Florida Statutes, is amended to read:

626.989 Investigation by department or Division of Insurance Fraud; compliance; immunity; confidential information; reports to division; division investigator's power of arrest.—

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

(a) A person commits a "fraudulent insurance act" if the person:

1. Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto.

2. Knowingly submits:

a. A false, misleading, or fraudulent application or other

document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400 with an intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law.

b. A claim for payment or other benefit pursuant to a personal injury protection insurance policy under the Florida Motor Vehicle No-Fault Law if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400. ~~For the purposes of this section,~~

(b) The term "insurer" also includes a ~~any~~ health maintenance organization, and the term "insurance policy" also includes a health maintenance organization subscriber contract.

Section 5. Subsection (5) of section 626.9894, Florida Statutes, is amended to read:

626.9894 Gifts and grants.—

(5) Notwithstanding ~~the provisions of~~ s. 216.301 and pursuant to s. 216.351, any balance of moneys deposited into the Insurance Regulatory Trust Fund pursuant to this section or s. 626.9895 remaining at the end of any fiscal year is ~~shall be~~ available for carrying out the duties and responsibilities of the division. The department may request annual appropriations from the grants and donations received pursuant to this section or s. 626.9895 and cash balances in the Insurance Regulatory Trust Fund for the purpose of carrying out its duties and

responsibilities related to the division's anti-fraud efforts, including the funding of dedicated prosecutors and related personnel.

Section 6. Section 626.9895, Florida Statutes, is created to read:

626.9895 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 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; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and 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 used exclusively to advance the prosecution, investigation, or prevention of motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of 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.

(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 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 if appropriate.

(c) Certification by the division that the 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 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.—

(a) The board of directors of the organization shall consist of the following eleven members:

1. The Chief Financial Officer, or designee, who shall serve as chair.

2. 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.

3. Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.

4. 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.

5. Two representatives of the types of health care providers who regularly make claims for benefits under ss. 627.730-627.7405, one of whom shall be appointed by the President of the Senate and one of whom shall be appointed by the Speaker of the House of Representatives. The appointees may not represent the same type of health care provider.

6. A private attorney that has experience in representing claimants in actions for benefits under ss. 627.730-627.7405, who shall be appointed by the President of the Senate.

7. A private attorney who has experience in representing insurers in actions for benefits under ss. 627.730-627.7405, who shall be appointed by the Speaker of the House of Representatives.

(b) 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 FROM INSURERS.—Contributions from an insurer to the organization shall be allowed as an appropriate business expense of the insurer for all regulatory purposes.

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

(8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by the division from the organization shall be deposited into the Insurance Regulatory Trust Fund.

Section 7. Subsection (12) of section 627.0651, Florida Statutes, is amended to read:

627.0651 Making and use of rates for motor vehicle insurance.—

(12)(a) Any portion of a judgment entered as a result of a

statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may ~~shall~~ not be included in the insurer's rate base~~,~~ and ~~shall not be~~ used to justify a rate or rate change. Any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may ~~shall~~ not be used to justify a rate or rate change. The portion of the taxable costs and attorney ~~attorney's~~ fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may ~~shall~~ not be included in the insurer's rate base and used ~~shall not be utilized~~ to justify a rate or rate change.

(b) Any portion of a judgment or settlement for taxable costs and attorney fees in favor of a prevailing plaintiff against an insurer in a claim for benefits under ss. 627.730-627.7405, the Florida Motor Vehicle No-Fault Law, may not be included in the insurer's rate base and used to justify a rate or rate change.

Section 8. Subsections (1), (4), (5), (6), (8), (9), (10), and (11) of section 627.736, Florida Statutes, are amended to read:

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

(1) REQUIRED BENEFITS.—An ~~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 the ~~such~~ motor vehicle, and other

persons struck by the ~~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)(e), 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 for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices~~,~~ and medically necessary ambulance, hospital, and nursing services. Medical benefits do not includes massage as defined in s. 480.033 or acupuncture as defined in s. 457.102. ~~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:

a. A health care clinic 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.

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 shall give priority to the payment of death benefits over the payment of other benefits of the deceased and, upon learning of the death of the individual, stop paying the other benefits until the death benefits are paid. The insurer may pay death ~~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~~.

Only insurers writing motor vehicle liability insurance in this

state may provide the required benefits of this section, and ~~no~~ such insurer may not ~~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 provided under that ~~afforded in such~~ part, as well as those provided ~~which may be afforded~~ elsewhere in the insurance code.

(4) PAYMENT OF BENEFITS~~; WHEN DUE~~.~~—~~Benefits due from an insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except that benefits received under any workers' compensation law must ~~shall~~ be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under 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 under ss. 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of~~ the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to 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 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. However:

1. If ~~such~~ written notice of the entire claim 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.

2. 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 if~~, provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must also ~~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.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification or explanation of benefits of the specified error. Upon receiving the specification or explanation, the person making the claim has, at the person's option and without waiving any other legal remedy for payment, 15 days to submit a revised claim, and the revised claim shall be considered a timely submission of written notice of a claim.

4. ~~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.

5. 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 that ~~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.

6. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in

violation of, subsection (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.

(c) 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:

1. 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.

2. Hospitals licensed under chapter 395.

The amount required to be held in reserve may be used only to pay claims from such physicians, ~~or~~ dentists, or hospitals 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 claims ~~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 such ~~a~~ physician, ~~or~~ dentist, or hospital ~~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.

(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. Interest is ~~shall be~~ due at the time payment of the overdue claim is made.

(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 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 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.

(f) If two or more insurers are liable for paying ~~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 the ~~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.

(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.

(h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the behalf of an insured person if that person has 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 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 in its entirety from the person who committed insurance fraud ~~in their entirety~~. The prevailing party is entitled to its costs and attorney ~~attorney's~~ fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. The insurer shall provide to the insured, or an assignee of the insured, a copy of the log within 30 days after receiving a request for the log from the insured or the assignee.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)~~1.~~ A ~~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 a charge may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. In determining ~~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 motor vehicle ~~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 may limit reimbursement to 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:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, 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 is ~~was~~ rendered and for the area in which such services, supplies, or care is ~~were~~ rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less

than the allowable amount under the applicable ~~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 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. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

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.

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the

insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(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 paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled 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

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 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 ~~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 an ~~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 and care 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 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 federal 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 at least 12-point type ~~in type no smaller than 12 points~~:

BILLING REQUIREMENTS.—Florida law provides ~~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 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 a ~~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 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 the ~~Healthcare Correct Procedural Coding System (~~HCPCS~~)~~. All providers, other than hospitals, must ~~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 properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(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;

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;

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. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. The ~~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 "countersign" or "countersignature" ~~"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.

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 ~~that~~ is consistent with the services being rendered to the patient as claimed. The requirement to maintain ~~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 a ~~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.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395; or

5. An entity wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395.

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

(a) ~~Every employer shall,~~ If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish ~~forthwith~~, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(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, 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 allow ~~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 section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. 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. As used in ~~For purposes of~~ this 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.

(c) In the event of a ~~any~~ dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and must ~~it shall~~ specify the time, place, manner, conditions, and scope of the discovery. ~~Such court may,~~ In order

to protect against annoyance, embarrassment, or oppression, as justice requires, the court may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under ~~the provisions of~~ this section, and ~~shall~~ pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim may ~~shall~~ not be unreasonably withheld by an insured.

(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, the insurer must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY ~~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 assignee of an insured's rights and the insurer, the provisions of ss. ~~s.~~ 627.428 and 768.79 ~~shall~~ apply, except as provided in subsections (10) and (15).

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract ~~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 ~~shall~~ include health care providers licensed under chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter

~~and~~ 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing ~~purchase of~~ the policy for personal injury protection benefits, if the requirements of this subsection are met. 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. If the insured elects to use a provider who is a preferred provider, 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. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. 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 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.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, ~~the insurer must be provided with~~ written notice of an intent to initiate litigation must be provided to the insurer. 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).

(b) The notice must ~~required 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 (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 are ~~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 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 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 ~~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) 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.~~

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.—

(a) ~~If~~ An insurer ~~fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, the insurer~~ is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 if the insurer, with such frequency so as to indicate a general business practice: ~~with respect thereto~~

1. Fails to pay valid claims for personal injury protection; or

2. Fails to pay valid claims until receipt of the notice required by subsection (10).

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

Section 9. Effective December 1, 2012, subsection (16) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits;

exclusions; priority; claims.—

(16) SECURE ELECTRONIC DATA TRANSFER.—~~If all parties mutually and expressly agree,~~ A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Section 10. Subsections (1), (10), and (13) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(1)(a) A person commits insurance fraud punishable as provided in subsection (11) if that person, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; ~~or~~

3.a. Knowingly presents, causes to be presented, or

prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract; or

b. ~~Who~~ Knowingly conceals information concerning any fact material to such application; or~~.~~

4. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer a claim for payment or other benefit under a personal injury protection insurance policy if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400.

(b) All claims and application forms must ~~shall~~ contain a statement that is approved by the Office of Insurance Regulation of the Financial Services Commission which clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree." This paragraph does ~~shall~~ not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

(10) A licensed health care practitioner who is found guilty of insurance fraud under this section for an act relating to a personal injury protection insurance policy loses his or her license to practice for 5 years and may not receive reimbursement for personal injury protection benefits for 10 years. ~~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.~~

(13) 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" means value as defined in s. 812.012.

Section 11. Subsection (4) of section 316.065, Florida Statutes, is amended to read:

316.065 Crashes; reports; penalties.—

(4) Any person who knowingly repairs a motor vehicle without having made a report as required by subsection (3) is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. The owner and driver of a vehicle involved in a crash who makes a report thereof in accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable under this section.

Section 12. The Office of Insurance Regulation shall

perform a comprehensive personal injury protection data call and publish the results by January 1, 2015. It is the intent of the Legislature that the office design the data call with the expectation that the Legislature will use the data to help evaluate market conditions relating to the Florida Motor Vehicle No-Fault Law and the impact on the market of reforms to the law made by this act. The elements of the data call must address, but need not be limited to, the following components of the Florida Motor Vehicle No-Fault Law:

(1) Quantity of personal injury protection claims.

(2) Type or nature of claimants.

(3) Amount and type of personal injury protection benefits paid and expenses incurred.

(4) Type and quantity of, and charges for, medical benefits.

(5) Attorney fees related to bringing and defending actions for benefits.

(6) Direct earned premiums for personal injury protection coverage, pure loss ratios, pure premiums, and other information related to premiums and losses.

(7) Licensed drivers and accidents.

(8) Fraud and enforcement.

Section 13. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 14. Except as otherwise expressly provided in this

act, this act shall take effect July 1, 2012.

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 1862
INTRODUCER:	Senator Negron
SUBJECT:	Public Records/Donor Identifying Information/Division of Insurance Fraud
DATE:	January 31, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Burgess	BI	**Favorable**
2.			GO	
3.				
4.				
5.				
6.				

I. Summary:

The bill creates a public records exemption for all identifying information of donors or prospective donors to the Automobile Insurance Fraud Strike Force a direct-support organization of the Division of Insurance Fraud.

The bill provides for repeal of the exemption on October 2, 2017, unless reviewed and saved from repeal by the Legislature. The bill also provides a statement of public necessity as required by the State Constitution.[1]

This bill amends the following section of the Florida Statutes: 626.9895

II. Present Situation:

Public Records Law

Article I, s. 24(a) of the State Constitution sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. The Legislature, however, may provide by general law for the exemption of records from the requirements of Article I, s. 24(a) of the State Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose. A bill enacting an exemption or substantially amending an

[1] Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a new exemption; thus, it requires a two-thirds vote for final passage.

existing exemption may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[2]

Public policy regarding access to government records is addressed further in the Florida Statutes. Section 119.07(1), F.S., guarantees every person a right to inspect and copy any state, county, or municipal record. Furthermore, the Open Government Sunset Review Act[3] provides that a public record or public meeting exemption may be created or maintained only if it serves an identifiable public purpose. In addition, it may be no broader than is necessary to meet one of the following purposes:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption.
- Protects sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision.
- Protects trade or business secrets.

Insurance Fraud Strike Force

Legislation proposed during the 2012 Legislative Session[4] creates the Automobile Insurance Fraud Strike Force a direct-support organization of the Division of Insurance Fraud. The strike force's sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The strike force is to be set up as a not-for-profit and shall be allowed to raise funds by requesting and receiving grants, gifts, and bequests of money.

III. Effect of Proposed Changes:

The bill creates a public records exemption for all identifying information of donors or prospective donors to the Automobile Insurance Fraud Strike Force a direct-support organization of the Division of Insurance Fraud.

The bill sets forth legislative findings of public necessity as the exemption is viewed as an essential component for the program to attract and receive donations from private funds. These funds shall be specifically used to prosecute, investigate and prevent motor vehicle insurance fraud.

The bill takes effect on the date that SB 1860, or similar legislation adopted by the Legislature during the 2012 Regular Legislative Session and subsequently enacted into law, takes effect.

[2] Section 24(c), Art. I of the State Constitution.
[3] Section 119.15, F.S.
[4] 2012 – SB 1860

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:

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.

By Senator Negron

28-01433-12 20121862__

A bill to be entitled

An act relating to public records; amending s. 626.9895, F.S., as created by Senate Bill ____; exempting from public record requirements all identifying information of a donor or prospective donor to the motor vehicle insurance fraud direct-support organization of the Division of Insurance Fraud; providing for future repeal and legislative review of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Subsection (9) is added to section 626.9895, Florida Statutes, as created by Senate Bill ____, to read:

626.9895 Motor vehicle insurance fraud direct-support organization.—

(9) DONOR CONFIDENTIALITY.—

(a) The identity of a donor or prospective donor to the organization who desires to remain anonymous and all other information identifying such donor or prospective donor are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such anonymity shall be maintained in the annual financial audit created pursuant to subsection (2).

(b) This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2017, unless reviewed and saved from repeal through reenactment by the Legislature.

28-01433-12 20121862__

Section 2. The Legislature finds that it is a public necessity that information identifying a donor or prospective donor to the Automobile Insurance Fraud Strike Force direct-support organization of the Division of Insurance Fraud be made confidential and exempt from public records requirements if such donor or prospective donor desires to remain anonymous. Fraudulent activity in the personal injury protection insurance system in this state has reached unprecedented levels. The direct-support organization is created for the purpose of supporting efforts by the Division of Insurance Fraud to investigate, prosecute, and prevent motor vehicle insurance fraud. In order to obtain support for the organization and its mission, it is necessary to promote the raising of private funds for these anti-fraud efforts. An essential element of such support is the need to protect the identity of prospective and actual donors who desire to remain anonymous. There is a chilling effect on donations when the identity of individual donors is subject to disclosure because donors are concerned about the disclosure of sensitive personal information, which can lead to theft, including identity theft, and jeopardize the personal safety and security of such individuals. The disclosure of the identity of an entity that is a prospective or actual donor can also provide competitors in the marketplace with insights into the finances of that entity and thereby cause injury to the entity. The chilling effect on donations would, in turn, impede the efforts of the state to combat motor vehicle insurance fraud. Therefore, the Legislature finds that it is a public necessity to make confidential and exempt from public records requirements information that would identify a donor or

prospective donor to the motor vehicle insurance fraud direct-support organization if such donor or prospective donor wishes to remain anonymous.

Section 3. This act shall take effect on the same date that Senate Bill ___ or similar legislation takes effect, if such legislation is adopted in the same legislative session, or an extension thereof, and becomes law.

160704

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment

Delete lines 211 - 245
and insert:
3. To a full-time salaried employee of a licensed general lines agent or to a business entity that offers travel planning services if insurance sales activities authorized by the license are in connection with, and incidental to, travel.
a. A license issued to a business entity that offers travel planning services must encompass each office, branch office, or place of business making use of the entity's business name in order to offer, solicit, and sell insurance pursuant to this

160704

paragraph.

b. The application for licensure must list the name, address, and phone number for each office, branch office, or place of business that is to be covered by the license. The licensee shall notify the department of the name, address, and phone number of any new location that is to be covered by the license before the new office, branch office, or place of business engages in the sale of insurance pursuant to this paragraph. The licensee shall notify the department within 30 days after the closing or terminating of an office, branch office, or place of business. Upon receipt of the notice, the department shall delete the office, branch office, or place of business from the license.

c. A licensed and appointed entity is directly responsible and accountable for all acts of the licensee's employees and parties with whom the licensee has entered into a contractual agreement to offer travel insurance.

A licensee shall require each individual ~~employee~~ who offers policies or certificates under subparagraph 2. or subparagraph 3. ~~this subparagraph~~ to receive initial training from a general lines agent or an insurer authorized under chapter 624 to transact insurance within this state. For an entity applying for a license as a travel insurance agent, the fingerprinting requirement of this section applies only to the president, secretary, and treasurer and to any other officer or person who directs or controls the travel insurance operations of the entity.

929464

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 245 and 246
insert:

Section 6. Present subsection (4) of section 626.753, Florida Statutes, is renumbered as subsection (6), and new subsections (4) and (5) are added to that section to read:

626.753 Sharing commissions; penalty.—

(4) Any patronage dividend or other payment, discount, or credit provided to a member of a production credit association or federal land bank association which is directly or indirectly calculated on the basis of the premium charged to that member

929464

for crop hail or multiple-peril crop insurance is an unlawful rebate in violation of ss. 626.572 and 626.9541(1)(h).

(5) An agent who engages in commission sharing with a production credit association or federal land bank association, and who has knowledge that the association provides patronage dividends or other payments, discounts, or credits that constitute unlawful rebates as described in subsection (4), is participating in a violation of this section.

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

And the title is amended as follows:

Delete line 18

and insert:

circumstances; amending s. 626.753, F.S., relating to the sharing of commissions; prohibiting certain rebates; creating s. 626.8675, F.S.; providing

604062

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 804 - 913.

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

And the title is amended as follows:

Delete lines 25 - 29

and insert:

company; creating s.

377322

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment

Delete line 919
and insert:
listed in s. 627.6561(5)(b)-(e), issued in any market, unless

467786

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 994
and insert:
Section 11. Effective upon this act becoming a law, subsection (4) of section 627.7295, Florida

Delete line 1030
and insert:
Section 13. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1,

467786

2012.

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

And the title is amended as follows:

Delete line 40

and insert:

protection benefits; providing effective dates.

464972

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 1006
and insert:
Section 12. Effective upon this act becoming a law, paragraph (d) of subsection (4) of section

Delete line 1030
and insert:
Section 13. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1,

464972

2012.

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

And the title is amended as follows:

Delete line 40

and insert:

protection benefits; providing effective dates.

227828

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment

Delete line 951
and insert:
counsel or any other person having relevant information is ~~shall be~~ permitted. Mediation under this section is

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic Insurance Omnibus

Bill Number SB 1620 *(if applicable)*

Name Joy Ryan

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 2041 S. Monroe St.
Street

_____
City *State* *Zip*

Phone 681-6710

E-mail joy@blankclaw.com

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic Omnibus Bill

Bill Number 1620 *(if applicable)*

Name Steve Roddenberry

Amendment Barcode *(if applicable)*

Job Title Special Consultant

Address 215 S. Monroe St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 222-3533

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing Sellers of Travel Products

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic Insurance Bill Number 1620 *(if applicable)*

Name Josh Aubuchon Amendment Barcode *(if applicable)*

Job Title ~~2[illegible] Monroe~~ attorney

Address 215 S. Monroe St. Phone
Street

Tallahassee FL 32301 E-mail
City *State* *Zip*

Speaking: ☑ For ☐ Against ☑ Information

Representing State Farm Mutual Automobile Insurance Corp.

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 1620
INTRODUCER:	Banking and Insurance Committee and Senator Richter
SUBJECT:	Insurance
DATE:	February 2, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.			BC	
3.				
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 changes a number of provisions relating to the regulation of insurance companies, insurance agents, insurance adjusters, and insurance coverage, including:

- Specifies that a salvage motor vehicle dealer is not required to carry the $25,000 combined single-limit liability coverage for bodily injury and property damage, or the $10,000 PIP coverage, for vehicles that have been issued a certificate of destruction and cannot be operated legally on state roads.
- Clarifies that a current exemption from filing specified reinsurance information applies to any insurer with less than $500,000 in direct written premiums in Florida in the preceding calendar year, as long as that insurer did not write more than $250,000 of premium during the preceding calendar quarter, or any insurer with less than 1,000 policyholders at the end of the preceding calendar year.
- Allows the DFS to provide licensing examinations in Spanish at the expense of the applicant.
- Expands the list of entities to whom a limited license for travel insurance may be issued.
- Prohibits a patronage dividend or other payment from being paid to a production credit association or a federal land bank association, if the payment is directly or indirectly based on the premium charged to that member for crop hail or multi-peril crop insurance.

- Allows a licensed independent adjuster or a licensed agent to supervise up to 25 individuals who are not required to obtain a license to perform functions in connection with entering data into an automated claims adjudication system for portable electronics insurance claims.
- Provides that a resident of Canada cannot obtain a license as a nonresident independent adjuster for the purpose of adjusting portable electronics insurance claims, unless the individual obtains an adjuster license in another U.S. state.
- Provides that an insurer with surplus as to policyholders of $25 million or less can qualify as an LAC for all statutory purposes.
- Provides that mandated health benefits are intended to apply only to the types of health benefit plans defined in s. 627.6699(3), F.S., unless specifically designated otherwise.
- Specifies that the alternative dispute resolution procedure for personal and commercial residential property insurance claims can be requested only by the policyholder, as a first-party claimant, or by the insurer.
- Provides that when the notice of loss is reported more than 36 months after a declaration of a state of emergency by the Governor in response to a hurricane, the alternative claim dispute resolution process is not available.
- Allows the cancellation of a private passenger motor vehicle insurance policy, regardless of whether the first 2 months of premiums need to be paid up front, within the first 60 days for non-payment of premium when the check or other method of payment presented is subsequently dishonored.
- Clarifies that when an insurer fails to meet the statutory requirements for timely payment of PIP benefits, the obligation will accrue interest at the rate established in the contract or the statutory interest rate that applies to judgments and decrees, whichever is greater, that is in effect on the date the payment became overdue.

The bill provides an effective date of July 1, 2012.

This bill substantially amends the following sections of the Florida Statutes: 320.27, 624.501, 624.610, 626.261, 626.321, 626.753, 627.351, 627.7015, 627.7295, and 627.736.

This bill substantially creates the following sections of the Florida Statutes: 626.8675 and 627.6011.

II. Present Situation:

Motor Vehicle Dealers

Section 320.27(3), F.S., requires motor vehicle dealers licensed in Florida to be insured under a garage liability insurance policy or a general liability policy and a business automobile policy which must include a minimum of $25,000 combined single-limit liability coverage for bodily injury and property damage, and $10,000 of personal injury protection (PIP). Section 320.27(1)(a), F.S., defines a "motor vehicle dealer" as any person engaged in the business of buying, selling or dealing in motor vehicles for sale at wholesale or retail, or who may service and repair motor vehicles. The definition specifies five separate classifications of motor vehicle dealers, one of which is a salvage motor vehicle dealer, which purchases salvaged or wrecked motor vehicles for the purpose of reselling the vehicle or its parts.

Reinsurance Filing Requirements

Section 624.610(11), F.S., establishes specified information that must be filed by domestic or commercially domiciled insurers that cede directly written risks of loss. Section 624.619(11)(c), F.S., specifies certain exemptions from the filing requirements, including any insurer with more than $100 million in surplus as to policyholders, less than $500,000 in direct written premiums in Florida in the preceding calendar year, or less than 1,000 policyholders at the end of the preceding calendar year. The statute then provides that any ceding insurer "otherwise subject to this section with more than $250,000 in direct written premiums written in this state during the preceding calendar quarter is not exempt from the requirements of this subsection." The placement of this last provision creates some ambiguity as to its application.

Agent License Examinations

The Department of Financial Services (DFS) is responsible for licensing insurance agents, service representatives and adjusters, under Part I of ch. 626, F.S., titled the "Licensing Procedures Law." Section 626.261, F.S., establishes requirements for conducting examinations for licensee candidates.

Limited Licenses

Section 626.321, F.S., establishes categories for which the DFS will issue a license that authorizes an agent to transact a limited class of business. The following enumerated categories qualify for limited license:

- Motor vehicle physical damage and mechanical breakdown insurance;
- Industrial fire or burglary insurance;
- Travel insurance;
- Motor vehicle rental insurance;
- Credit life or disability insurance;
- Credit insurance;
- Credit property insurance;
- Crop hail and multi-peril crop insurance;
- In-transit and storage personal property insurance; and
- Communications equipment property insurance, communications equipment inland marine insurance, and communications equipment service warranty insurance.

Under a limited license for travel insurance, the policy or certificate of travel insurance can cover risks incidental to travel, planned travel, or accommodations while traveling, including:

- Accidental death and dismemberment;
- Trip cancellation, interruption or delay;
- Loss or damage to personal effects or travel documents;
- Baggage delay;
- Emergency medical travel or evacuation;
- Medical, surgical, or hospital expenses arising from an illness or emergency.

The travel insurance must be limited to travel or accommodations of no more than 60 days, but the policy or certificate can be issued for a term that exceeds 60 days. A limited license for travel insurance may be issued only to:

- A full-time salaried employee of a common carrier or a transportation ticket agency in connection with the sale of transportation tickets;
- An entity or individual that is a developer of a timeshare plan of an approved public offering statement;
- An entity or individual that is an exchange company operating an approved exchange program;
- An entity or individual that is a managing entity operating a timeshare plan;
- An entity or individual that is a seller of travel; or
- An entity or individual that is an affiliate of any of the listed entities.

Agents Sharing Commissions

Section 626.753, F.S., provides that an agent may divide or share commissions only with other agents appointed and licensed to write the same kinds of insurance. An agent cannot share a commission with any corporation unless that corporation is an insurance agency.

Section 626.753(3), F.S., provides that a general lines agent may share commissions from the sale of crop hail or multi-peril crop insurance with a production credit association or a federal land bank association, if the association has approved the insurance activity by its employees.

Insurance Adjusters

Insurance adjusters are regulated by the DFS under part VI of ch. 626, F.S., entitled the "Insurance Adjusters Law."[1] Section 626.852, F.S., explicitly provides that the Insurance Adjusters Law does not apply to:

- Life insurance or annuity contracts;
- Third party administrators with a certificate of authority, or individuals employed by third party administrators;
- Any employee or agent of a state university board of trustees providing services for a self-insurance program; or
- Any person who adjusts only multi-peril crop insurance or crop hail insurance.

Section 626.862, F.S., provides that a licensed and appointed insurance agent is authorized to adjust claims for the insurers for which the agent is appointed, without obtaining a license as an adjuster.

The Insurance Adjusters Law provides separate definitions and separate requirements for public adjusters,[2] independent adjusters,[3] company employee adjusters,[4] nonresident company

[1] Section 626.851, F.S.
[2] Section 626.854, F.S.
[3] Section 626.855, F.S.
[4] Section 626.856, F.S.

employee adjusters,[5] nonresident public adjusters,[6] and nonresident independent adjusters.[7] A nonresident independent adjuster is defined as a person who:

- Is a resident of Florida;
- Is a licensed independent adjuster in the state of residence, or if the state of residence does not license independent adjusters, the nonresident must have passed the relevant Florida examination for licensure; and
- Is a self-employed independent adjuster or is associated with or employed by an independent adjuster firm or other independent adjuster.

Additional requirements for nonresident independent adjusters are contained in s. 626.8734, F.S.

Limited Apportionment Companies

A limited apportionment company (LAC) is a company with surplus as to policyholders below a certain prescribed level. Four separate sections in current law have established apparently conflicting requirements necessary to qualify as an LAC. Section 627.351(2)(b)3., F.S., provides a threshold of $20 million or less of surplus as to policyholders to qualify as an LAC. Section 627.351(6)(c)13., F.S., provides a threshold of $25 million or less of surplus as to policyholders to qualify as an LAC. Further, s. 215.555(4)(e)3.,F.S., specifically references the $20 million definition of LAC under s. 627.351(2)(b)3., F.S.; however, s. 215.555(4)(b)4., F.S., specifically references the $25 million definition of LAC under s. 627.351(6)(c), F.S.

Section 627.351(2)(b)3., F.S., established the Windstorm Insurance Risk Apportionment plan, and authorized the OIR to adopt a plan for the equitable apportionment of windstorm coverage among insurers authorized to transact property insurance on a direct basis in Florida.[8] Section 627.351(2)(b)3., F.S., requires that the plan provide that any member insurer with $20 million or less of surplus as to policyholders can apply with OIR to qualify as an LAC. The section specifies that the apportionment of windstorm loss to an LAC cannot exceed that LAC's gross participation, and the LAC cannot be required to participate in marketwide aggregate windstorm losses exceeding $50 million. Further, if the OIR determines that any regular assessment will result in the impairment of surplus of an LAC, the OIR must direct that LAC's share of the assessment to be deferred.

Because all residual market windstorm risk is now covered by Citizens Property Insurance Corporation (Citizens) under s. 627.351(6), F.S., the Windstorm Insurance Risk Apportionment plan created by s. 627.351(2), F.S., is no longer active. Nevertheless, the $20 million threshold that it establishes to qualify as an LAC is still in effect through a cross-reference from legislation regulating the Florida Hurricane Catastrophe Fund (FCHF) under ch. 215, F.S.

Section 215.555(4)(e)3., F.S., specifically references the definition of limited apportionment companies under s. 627.351(2)(b)3., F.S., for the purpose of allowing the FHCF to advance the amount of estimated reimbursement payable to an LAC under the FHCF contract. Accordingly,

[5] Section 262.858, F.S.
[6] Section 626.8582, F.S.
[7] Section 626.8584, F.S.
[8] Section 627.351(2)(b), F.S.

only those companies with surplus at or below $20 million could qualify to receive the advance from the FHCF.

Section 627.351(6), F.S., establishes Citizens Property Insurance Corporation, and s. 627.351(6)(c)13., F.S., specifies that the Citizens' plan of operation must provide that any assessable insurer with surplus as to policyholders of $25 million or less may petition the OIR to qualify as an LAC, for the purpose of allowing the LAC to pay any regular assessment on a monthly basis as the assessments are collected by the LAC from its policyholders. Further, if the OIR determines that any regular assessment will result in the impairment of surplus of an LAC, the OIR must direct that LAC's share of the assessment be deferred.

The $25 million threshold for LACs also has a statutory cross-reference tying it into the statutes regulating the FHCF. Section 215.555(4)(b)4., F.S., specifically references the definition of limited apportionment companies under s. 627.351(6)(c), F.S., for the purpose of allowing the LACs to participate in an additional layer of FHCF coverage not otherwise available. Accordingly, those companies with surplus up to $25 million could qualify as LACs for participating in the additional layer of FHCF coverage.

Mandated Health Benefit Coverages

Sections 627.6401, F.S., through 627.64193, F.S., there are 17 different statutory sections that impose various forms of mandatory health benefits that must be included in every health insurance policy, unless an exception is designated within the statutory section that describes the specific mandate being imposed. Many of the mandates provide for exceptions within the specific section that imposes the mandate, as follows:

- Section 627.6406, F.S., Maternity care, explicitly exempts health insurance coverage that does not provide for hospitalization in connection with childbirth.
- Section 627.6408, F.S., Osteoporosis screening, does not apply to "specific-accident, specific-disease, hospital indemnity, Medicare supplement, or long-term care health insurance, or the state employee health insurance program."
- Section 627.641, F.S., Newborn children, does not apply to disability income or hospital indemnity policies, or to normal maternity policy provisions.
- Section 627.6416, F.S., Child health supervision services, does not apply to "disability income, specified disease, Medicare supplement, or hospital indemnity policies."
- Section 627.6417, F.S., Surgical procedures and devices incident to mastectomy, does not apply to "disability income, specified disease other than cancer, or hospital indemnity policies."
- Section 627.64171, F.S., Outpatient postsurgical care, does not apply to "disability income, specified diseases other than cancer, or hospital indemnity policies."
- Section 627.6418, F.S., Mammograms, does not apply to "disability income, specified disease, or hospital indemnity policies."
- Section 627.64193, F.S., Cleft lip and cleft palate, does not apply to "specified-accident, specified-disease, hospital indemnity, limited benefit disability income, or long-term care insurance policies."

Alternative Procedure for Claim Dispute Resolution

Section 627.7015, F. S., establishes procedures for a mediated claim resolution process for all claimants and insureds under personal lines and commercial residential policies. The process is available prior to the commencing of the appraisal process or commencing litigation. If requested by the insured, legal counsel is permitted. The process explicitly excludes commercial coverages, motor vehicle coverages, or liability disputes on a property insurance policy. When a first party claim is filed for the mediation process, the insurer is obligated to notify all first-party claimants of their right to participate in the mediation program. If the insurer fails to comply with its obligations, the insured is relieved from any contractual obligation to participate in the loss appraisal process as a precondition to legal action. For purposes of the alternative dispute resolution procedure, the term "claim" means any dispute between an insurer and an insured over a material issue of fact, with four exceptions, specified as follows:

- When the insurer has a reasonable basis to suspect fraud;
- When, based on agreed-upon facts as to the cause of the loss, there is no coverage under the policy;
- When the insurer has a reasonable basis to believe the claimant has intentionally made a material misrepresentation relevant to the claim, and the entire claim is denied based on the misrepresentation;
- When the controversy is less than $500, unless the parties agree to mediate the dispute.

Cancellation of Motor Vehicle Insurance Policies

Prior to the effective date of a private passenger motor vehicle insurance policy or a binder for such a policy, the insurer or agent must collect from the insured an amount equal to 2 months premium. This is not applicable if:

- The insured or member of the insured's family is renewing or replacing a policy or a binder for such policy written by the same insurer or a member of the same insurer group.
- The insurer issues private passenger motor vehicle coverage primarily to active duty or former military personnel or their dependents.
- All policy payments are paid through a payroll deduction plan or an automatic electronic funds transfer payment plan from the policyholder.[9]

For policies under which the first 2 months of premium are not required to be paid up front, the insurer may not cancel the new policy or binder during the first 60 days immediately following the effective date of the policy or binder except for nonpayment of premium.

Overdue Payments of Personal Injury Protection (PIP) Benefits

Section 627.736(4)(d), F.S., provides that when an insurer fails to meet the statutory requirements for timely payment of PIP benefits, the obligation will accrue interest at the rate established in the contract or the statutory interest rate established to apply to judgments and decrees,[10] whichever is greater. The interest rate for judgments is established by the Chief

[9] Section 627.7295(7), F.S.
[10] Section 55.03, F.S.

Financial Officer (CFO) four times[11] a year to apply to each calendar quarter in the year.[12] The CFO is to average the discount rate of the Federal Reserve Bank of New York for the preceding 12 months, then add 400 basis points. The statute states that the interest is to be applied "for the year in which the payment became overdue." [13]

III. Effect of Proposed Changes:

Section 1 amends s. 320.27, F.S., relating to requirements imposed on licensed Florida motor vehicle dealers. The bill specifies that a salvage motor vehicle dealer, as defined in s. 320.27(1)(c)5., F.S., is not required to carry the $25,000 combined single-limit liability coverage for bodily injury and property damage, or the $10,000 PIP coverage, for vehicles that have been issued a certificate of destruction and cannot be operated legally on state roads. The liability and PIP coverage requirements cover risk that arises only when a motor vehicle is being driven; this provision of the bill removes the requirement of coverage for vehicles that cannot be driven.

Section 2 amends s. 624.501(9), F.S., relating to the fees applicable for the original appointment and biennial renewal fee for limited appointments as agents. Current law provides a fee of $60 (including tax) for the original appointment fee and the biennial renewal fee for an appointment for each agent, with an exception that is applicable only to agents selling or soliciting motor vehicle rental insurance. For those limited agents, the original appointment fee and the biennial renewal fee is also $60, but the fee is not required to be paid for each individual that sells the product, but rather the fee must be paid only for each office, branch office, or place of business covered by the license.

The bill adds travel insurance to the exception that is currently applicable only to motor vehicle rental insurance. As a result, for the sale of travel insurance, an insurer would be required to pay the $60 original appointment fee and the $60 biennial renewal fee only for each office, branch office, or place of business covered by the license.

Section 3 amends s. 624.610(11)(c), F.S., by clarifying that the exemption from filing specified reinsurance information applies to any insurer with less than $500,000 in direct written premiums in Florida in the preceding calendar year, as long as that insurer did not write more than $250,000 of premium during the preceding calendar quarter, or to any insurer with less than 1,000 policyholders at the end of the preceding calendar year, or to any insurer with more than $100 million in surplus as to policyholders.

Section 4 creates s. 626.261(5), which allows the DFS to provide licensing examinations in Spanish. Applicants seeking to be given an examination in Spanish must bear the full cost incurred by the DFS in developing, administering, grading and evaluating the examination. In determining whether to allow the examination to be translated and administered in Spanish, the DFS must consider the percentage of population who speak Spanish.

[11] The CFO is to establish the interest rate on December 1, March 1, June 1, and September 1.
[12] The quarters are specified as beginning January 1, April 1, July 1, and October 1.
[13] Section 627.736(4)(d), F.S.

Section 5 amends s. 626.321, F.S., relating to limited agent licenses. The bill removes a current reference to the OIR's review of travel insurance under s. 624.605(1)(q), F.S., which refers to a miscellaneous subcomponent of the definition of casualty insurance. The bill adds event cancellation and damage to travel accommodations as permissible perils for inclusion under travel insurance. The bill increases the maximum allowable duration of travel or accommodations which a travel insurance policy or certificate may cover from the current 60 days limit to 90 days. The bill expands the list of individuals or entities to whom a limited license for travel insurance may be issued to include full-time salaried employees of a licensed general lines agent and business entities that offer travel planning services when the insurance activities are in connection with travel, providing:

- The license issued to a business entity offering travel planning services encompasses each office, branch office, or place of business using the entity's business name to sell insurance;
- The application for licensure must list the name, address, and phone number for each place of business covered under the license, and the licensee is obligated to provide updated information to the DFS for every place of business that is added to or deleted from the license within 30 days of the change.
- The licensed entity is directly responsible for the acts of those acting under the license.

Section 6 amends s. 626.753, F.S., relating to the sharing of agents' commissions. The bill prohibits a patronage dividend or other payment from being paid to a production credit association or a federal land bank association, if the payment is directly or indirectly based on the premium charged to that member for crop hail or multi-peril crop insurance. The bill specifies that any such payment is an unlawful rebate in violation of ss. 626.573, F.S., and 626.9541(1)(h), F.S. The bill further provides that an agent engaging in commission sharing with a production credit association or a federal land bank association, who has knowledge that the association is providing patronage dividends or other payments is in violation of the unlawful rebate provisions.

Section 7 creates s. 626.8675, F.S., providing an exemption from part VI of ch. 626, F.S., for portable electronics insurance claims employees. The bill allows a licensed independent adjuster or a licensed agent to supervise up to 25 individuals who are not required to obtain a license to perform functions in connection with entering data into an automated claims adjudication system. "Automated claims adjudication system" is defined as a preprogrammed computer system for the resolution of portable electronics insurance claims, as long as the system:

- Is used only by a licensed independent adjuster, a licensed agent, or an individual supervised under this provision;
- Complies with all claims payment requirements of the Florida Insurance Code; and
- Is certified as compliant by a licensed independent adjuster who is an officer of a business entity licensed under ch. 626, F.S.

The bill provides that a resident of Canada cannot obtain a license as a nonresident independent adjuster for the purposes of adjusting portable electronics insurance claims, unless the individual obtains an adjuster license in another U.S. state.

Section 8 amends s. 627.351.(2)(b)3., F.S. The bill changes the threshold level of surplus to qualify as an LAC under this section from the current $20 million to $25 million. As a result, the statutory definitions and cross-references for LACs will be consistent. An insurer with surplus as

to policyholders of $25 million or less can qualify as an LAC for all statutory purposes, including being qualified to receive advances from the FHCF under s. 215.555(4)(e)3., F.S.

Section 9 creates s. 627.6011, F.S., relating to mandated health insurance coverages. The bill provides that, rather than the current practice of designating all exemptions within each statutory section that describes the specific mandate being imposed, every "mandatory health benefit" applies only to the type of health benefit plan defined in s. 627.6699(3), F.S.,[14] unless the mandate specifically designates otherwise. The bill defines "mandatory health benefits" to mean those set forth in s. 627.6401, F.S., through s. 627.64193, F.S., along with any cross-references, and all mandatory treatment or health coverages or benefits that are enacted after the effective date of the bill.

Section 10 amends s. 627.7015, F.S., relating to alternative procedures for claim dispute resolution for personal lines and commercial residential property insurance. The bill specifies that the alternative dispute resolution procedure can be requested only by the policyholder, as a first-party claimant, or by the insurer. For all purposes within the alternative dispute resolution procedure, every current reference to either "insured" or "first-party claimant" is replaced in the bill with the term "policyholder." The bill adds an exception to the circumstances under which a claim would qualify for the alternative procedure for claim dispute resolution. Under current law, for purposes of the alternative dispute resolution procedure, the term "claim" means any dispute between an insurer and an insured over a material issue of fact, with four specified exceptions. The bill adds a fifth specific exception, namely that when the notice of loss is reported more than 36 months after a declaration of a state of emergency by the Governor in response to a hurricane, the alternative claim dispute resolution process is not available.

Section 11 amends s. 627.7295, F.S., relating to motor vehicle insurance contracts. The bill allows the cancellation of a private passenger motor vehicle insurance policy, regardless of whether the first 2 months of premiums need to be paid up front, within the first 60 days for nonpayment of premium when the check or other method of payment presented is subsequently dishonored. The bill also removes current language that limits the cancellation of policies within the first 60 days only for the reason of nonpayment of premium. This section is effective upon the act becoming a law.

Section 12 amends s. 627.736, F.S., by clarifying that when an insurer fails to meet the statutory requirements for timely payment of PIP benefits, the obligation will accrue interest at the rate established in the contract or the statutory interest rate that applies to judgments and decrees, whichever is greater, that is in effect on the date the payment became overdue. This provision specifies a more precise date than the current statutory language which states that the interest is to be applied "for the year in which the payment became overdue." This section is effective upon the act becoming a law.

Section 13 provides an effective date of July 1, 2012, except for sections 11 and 12, which are effective upon the act becoming a law.

[14] Section 627.6699(3)(b), F.S., defines the "basic health benefit plan" and the "standard health benefit plan," with a cross reference s. 627.6699(12), F.S. Section 627.6699(3)(k), F.S., defines "health benefit plan." Section 627.6699(3)(m), F.S., defines "limited benefit policy or contract," to provide specified-disease or specified-accident coverage, or one that fulfills an experimental or reasonable need.

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:

Salvage motor vehicle dealers will save the cost of the premiums for the purchase of the $25,000 combined single-limit liability coverage for bodily injury and property damage, and the $10,000 PIP coverage, for vehicles that have been issued a certificate of destruction and cannot be operated legally on state roads.

A residential property insurer with surplus as to policyholders of greater than $20 million, but not more than $25 million can now qualify as an LAC for the purpose of receiving advances from the FHCF under s. 215.555(4)(e)3.

C. Government Sector Impact:

The bill allows the DFS to administer licensing examinations in Spanish, depending on the percentage of the population who speak Spanish. If the DFS determines that it will provide examinations in Spanish, it will incur incremental costs to develop, administer, and grade the Spanish examinations. The DFS estimates that the development of new examination would be $45,000. These incremental costs are to be borne by the applicants who elect to take the examinations in Spanish. Based on data obtained from Texas, which administers a Spanish translation examination, the DFS estimates that a candidate taking the Spanish translation examination would pay $341 for the examination, rather than the current cost of $43 to take the examination in English.

The DFS reports that in order to comply with the bill's procedure for travel insurance agents, it will need to make changes to its computer system, which it estimates will cost approximately $5,000.

Provisions in the bill will require policy contract changes for travel insurance, motor vehicle insurance, health insurance and residential property insurance contracts and rates. The OIR anticipates that its product review units will have significant workload increases. The amount of this impact is indeterminate at this point.

VI. Technical Deficiencies:

Section 9 of the bill specifies that mandatory health benefits are to be applied only to the types of health benefit plan that is defined in s. 627.6699(3), F.S., unless specifically designated otherwise. However, s. 627.6699(3)(m), F.S., defines "limited benefit policy or contract," as providing specified-disease or specified-accident coverage. These are two of the most prevalent exemptions from mandated coverages under current law.

VII. Related Issues:

Section 6 of the bill defines an "automated claims adjudication system" as a preprogrammed computer system used to resolve portable electronics insurance claims. The term portable electronics insurance is not currently defined in the insurance code nor in the bill.

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 Banking and Insurance on February 2, 2012:

The CS prohibits a patronage dividend or other payment from being be paid to a production credit association or a federal land bank association, if the payment is directly or indirectly based on the premium charged to that member for crop hail or multi-peril crop insurance, and specifies that any such payment is an unlawful rebate in violation of ss. 626.573, F.S., and 626.9541(1)(h), F.S.

The CS removes provisions in the original bill that would have established 120 days as the notice requirement for cancelling or nonrenewing residential property insurance policies in most circumstances.

The CS provides that if requested by the policyholder, any person having relevant information would be allowed to attend a session of the mediated claim resolution process for personal lines and commercial residential policies.

The CS provides that sections 11 and 12 of the bill are to be effective upon the act becoming a law.

B. Amendments:

None.

By Senator Richter

37-00755D-12 20121620__

A bill to be entitled

An act relating to insurance; amending s. 320.27, F.S.; providing that a salvage motor vehicle dealer is not required to carry certain insurance on vehicles that have been issued a certificate of destruction; amending s. 624.501, F.S.; conforming a cross-reference; amending s. 624.610, F.S.; revising provisions specifying which insurers are not subject to certain filing requirements relating to reinsurance; amending s. 626.261, F.S.; authorizing the Department of Financial Services to provide examinations in Spanish; amending s. 626.321, F.S.; revising provisions relating to limited licenses for travel insurance; providing that a full-time salaried employee of a licensed general lines agent or a business entity that offers travel planning services may be issued such license under certain circumstances; creating s. 626.8675, F.S.; providing that provisions relating to insurance adjusters do not apply to individuals who conduct data entry into an automated claims adjustment system for portable electronics insurance claims; amending s. 627.351, F.S.; increasing the amount of surplus required for an association to qualify as a limited apportionment company; amending s. 627.4133, F.S.; revising provisions relating to the notice that an insurer must provide to an insured regarding the nonrenewal, cancellation, or termination of a commercial residential property insurance policy; creating s.

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627.6011, F.S.; providing that mandatory health benefits apply only to certain health benefit plans; amending s. 627.7015, F.S.; revising provisions relating to alternative procedures for the resolution of disputed property insurance claims; amending s. 627.7295, F.S.; revising provisions relating to cancellation for nonpayment of premiums for motor vehicle insurance; amending s. 627.736, F.S.; clarifying provisions relating to the amount of interest on overdue payments for personal injury protection benefits; providing an effective date.

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

Section 1. Subsection (3) of section 320.27, Florida Statutes, is amended to read:

320.27 Motor vehicle dealers.—

(3) APPLICATION AND FEE.—The application for the license shall be in such form as may be prescribed by the department and shall be subject to such rules with respect thereto as may be so prescribed by it. Such application shall be verified by oath or affirmation and shall contain a full statement of the name and birth date of the person or persons applying therefor; the name of the firm or copartnership, with the names and places of residence of all members thereof, if such applicant is a firm or copartnership; the names and places of residence of the principal officers, if the applicant is a body corporate or other artificial body; the name of the state under whose laws the corporation is organized; the present and former place or

places of residence of the applicant; and prior business in which the applicant has been engaged and the location thereof. Such application shall describe the exact location of the place of business and shall state whether the place of business is owned by the applicant and when acquired, or, if leased, a true copy of the lease shall be attached to the application. The applicant shall certify that the location provides an adequately equipped office and is not a residence; that the location affords sufficient unoccupied space upon and within which adequately to store all motor vehicles offered and displayed for sale; and that the location is a suitable place where the applicant can in good faith carry on such business and keep and maintain books, records, and files necessary to conduct such business, which will be available at all reasonable hours to inspection by the department or any of its inspectors or other employees. The applicant shall certify that the business of a motor vehicle dealer is the principal business which shall be conducted at that location. Such application shall contain a statement that the applicant is either franchised by a manufacturer of motor vehicles, in which case the name of each motor vehicle that the applicant is franchised to sell shall be included, or an independent (nonfranchised) motor vehicle dealer. Such application shall contain such other relevant information as may be required by the department, including evidence that the applicant is insured under a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy, which shall include, at a minimum, $25,000 combined single-limit liability coverage including bodily injury and property damage protection and

$10,000 personal injury protection. However, a salvage motor vehicle dealer as defined in subparagraph (1)(c)5. is exempt from the requirements for garage liability insurance and personal injury protection insurance on those vehicles that have been issued a certificate of destruction and cannot be operated legally on state roads, highways, or streets. Franchise dealers must submit a garage liability insurance policy, and all other dealers must submit a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy. Such policy shall be for the license period, and evidence of a new or continued policy shall be delivered to the department at the beginning of each license period. Upon making initial application, the applicant shall pay to the department a fee of $300 in addition to any other fees now required by law; upon making a subsequent renewal application, the applicant shall pay to the department a fee of $75 in addition to any other fees now required by law. Upon making an application for a change of location, the person shall pay a fee of $50 in addition to any other fees now required by law. The department shall, in the case of every application for initial licensure, verify whether certain facts set forth in the application are true. Each applicant, general partner in the case of a partnership, or corporate officer and director in the case of a corporate applicant, must file a set of fingerprints with the department for the purpose of determining any prior criminal record or any outstanding warrants. The department shall submit the fingerprints to the Department of Law Enforcement for state processing and forwarding to the Federal Bureau of Investigation for federal processing. The actual cost

of state and federal processing shall be borne by the applicant and is in addition to the fee for licensure. The department may issue a license to an applicant pending the results of the fingerprint investigation, which license is fully revocable if the department subsequently determines that any facts set forth in the application are not true or correctly represented.

Section 2. Paragraph (b) of subsection (9) of section 624.501, Florida Statutes, is amended to read:

624.501 Filing, license, appointment, and miscellaneous fees.—The department, commission, or office, as appropriate, shall collect in advance, and persons so served shall pay to it in advance, fees, licenses, and miscellaneous charges as follows:

(9)

(b) For all limited appointments as agent, as provided ~~for~~ in s. 626.321(1)(c) and (d) ~~626.321(1)(d)~~, the agent's original appointment and biennial renewal or continuation thereof for each insurer is ~~shall be~~ equal to the number of offices, branch offices, or places of business covered by the license multiplied by the fees set forth in paragraph (a).

Section 3. Paragraph (c) of subsection (11) of section 624.610, Florida Statutes, is amended to read:

624.610 Reinsurance.—

(11)

(c) This subsection applies to cessions of directly written risk or loss. This subsection does not apply to contracts of facultative reinsurance or to any ceding insurer that has a ~~with~~ surplus as to policyholders which ~~that~~ exceeds $100 million as of the immediately preceding December 31. A ~~Additionally, any~~

ceding insurer otherwise subject to this section which had ~~with~~ less than $500,000 in direct premiums written in this state during the preceding calendar year and no more than $250,000 in direct premiums written in this state during the preceding calendar quarter, or which had ~~with~~ less than 1,000 policyholders at the end of the preceding calendar year, is exempt from ~~the requirements of~~ this subsection. ~~However, any ceding insurer otherwise subject to this section with more than $250,000 in direct premiums written in this state during the preceding calendar quarter is not exempt from the requirements of this subsection.~~

Section 4. Subsection (5) is added to section 626.261, Florida Statutes, to read:

626.261 Conduct of examination.—

(5) The department may provide licensure examinations in Spanish. Applicants requesting examination or reexamination in Spanish must bear the full cost of the department's development, preparation, administration, grading, and evaluation of the Spanish-language examination. When determining whether it is in the public interest to allow the examination to be translated into and administered in Spanish, the department shall consider the percentage of the population who speak Spanish.

Section 5. Paragraph (c) of subsection (1) of section 626.321, Florida Statutes, is amended to read:

626.321 Limited licenses.—

(1) The department shall issue to a qualified individual, or a qualified individual or entity under paragraphs (c), (d), (e), and (i), a license as agent authorized to transact a limited class of business in any of the following categories:

(c) *Travel insurance.*—License covering only policies and certificates of travel insurance, which are subject to review by the office ~~under s. 624.605(1)(q)~~. Policies and certificates of travel insurance may provide coverage for risks incidental to travel, planned travel, or accommodations while traveling, including, but not limited to, accidental death and dismemberment of a traveler; trip or event cancellation, interruption, or delay; loss of or damage to personal effects or travel documents; damages to travel accommodations; baggage delay; emergency medical travel or evacuation of a traveler; or medical, surgical, and hospital expenses related to an illness or emergency of a traveler. ~~Any~~ Such policy or certificate may be issued for terms longer than 90 ~~60~~ days, but ~~each policy or certificate~~, other than a policy or certificate providing coverage for air ambulatory services only, each policy or certificate must be limited to coverage for travel or use of accommodations of no longer than 90 ~~60~~ days. The license may be issued only:

1. To a full-time salaried employee of a common carrier or a full-time salaried employee or owner of a transportation ticket agency and may authorize the sale of such ticket policies only in connection with the sale of transportation tickets, or to the full-time salaried employee of such an agent. ~~No~~ Such policy may not ~~shall~~ be for ~~a duration of~~ more than 48 hours or more than ~~for~~ the duration of a specified one-way trip or round trip.

2. To an entity or individual that is:

a. The developer of a timeshare plan that is the subject of an approved public offering statement under chapter 721;

b. An exchange company operating an exchange program approved under chapter 721;

c. A managing entity operating a timeshare plan approved under chapter 721;

d. A seller of travel as defined in chapter 559; or

e. A subsidiary or affiliate of any of the entities described in sub-subparagraphs a.-d.

A licensee shall require each individual ~~employee~~ who offers policies or certificates under this subparagraph to receive initial training from a general lines agent or an insurer authorized under chapter 624 to transact insurance within this state. For an entity applying for a license as a travel insurance agent, the fingerprinting requirement of this section applies only to the president, secretary, and treasurer and to any other officer or person who directs or controls the travel insurance operations of the entity.

3. To a full-time salaried employee of a licensed general lines agent or to a business entity that offers travel planning services if insurance sales activities authorized by the license are in connection with, and incidental to, travel.

a. A license issued to a business entity that offers travel planning services must encompass each office, branch office, or place of business making use of the entity's business name in order to offer, solicit, and sell insurance pursuant to this paragraph.

b. The application for licensure must list the name, address, and phone number for each office, branch office, or place of business that is to be covered by the license. The

licensee shall notify the department of the name, address, and phone number of any new location that is to be covered by the license before the new office, branch office, or place of business engages in the sale of insurance pursuant to this paragraph. The licensee shall notify the department within 30 days after the closing or terminating of an office, branch office, or place of business. Upon receipt of the notice, the department shall delete the office, branch office, or place of business from the license.

c. A licensed and appointed entity is directly responsible and accountable for all acts of the licensee's employees and parties with whom the licensee has entered into a contractual agreement to offer travel insurance.

Section 6. Section 626.8675, Florida Statutes, is created to read:

626.8675 Portable electronics insurance claims employee exemption.—

(1) This part does not apply to individuals who collect claims information from, or furnish claims information to, insureds or claimants, and who conduct data entry, including entering data into an automated claims adjudication system, if such individuals are employees of a business entity licensed under this chapter, or its affiliate, where up to 25 such individuals are under the supervision of a licensed independent adjuster or licensed agent who is exempt from licensure pursuant to s. 626.862. For purposes of this section, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of portable electronics insurance claims that:

(a) May be used only by a licensed independent adjuster, licensed agent, or supervised individual operating pursuant to this section;

(b) Must comply with all claims payment requirements of the insurance code; and

(c) Must be certified as compliant with this section by a licensed independent adjuster who is an officer of a licensed business entity under this chapter.

(2) Notwithstanding any other provision of law, a resident of Canada may not be licensed as a nonresident independent adjuster for purposes of adjusting portable electronics insurance claims unless that person has successfully obtained an adjuster license in another state.

Section 7. Paragraph (b) of subsection (2) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(2) WINDSTORM INSURANCE RISK APPORTIONMENT.—

(b) The department shall require all insurers holding a certificate of authority to transact property insurance on a direct basis in this state, other than joint underwriting associations and other entities formed pursuant to this section, to provide windstorm coverage to applicants from areas determined to be eligible pursuant to paragraph (c) who in good faith are entitled to, but are unable to procure, such coverage through ordinary means; or it shall adopt a reasonable plan or plans for the equitable apportionment or sharing among such insurers of windstorm coverage, which may include formation of an association for this purpose. As used in this subsection, the term "property insurance" means insurance on real or personal

property, as defined in s. 624.604, including insurance for fire, industrial fire, allied lines, farmowners multiperil, homeowners' multiperil, commercial multiperil, and mobile homes, and including liability coverages on all such insurance, but excluding inland marine as defined in s. 624.607(3) and excluding vehicle insurance as defined in s. 624.605(1)(a) other than insurance on mobile homes used as permanent dwellings. The department shall adopt rules that provide a formula for the recovery and repayment of any deferred assessments.

1. For the purpose of this section, properties eligible for such windstorm coverage are defined as dwellings, buildings, and other structures, including mobile homes which are used as dwellings and which are tied down in compliance with mobile home tie-down requirements prescribed by the Department of Highway Safety and Motor Vehicles pursuant to s. 320.8325, and the contents of all such properties. An applicant or policyholder is eligible for coverage only if an offer of coverage cannot be obtained by or for the applicant or policyholder from an admitted insurer at approved rates.

2.a.(I) All insurers required to be members of such association shall participate in its writings, expenses, and losses. Surplus of the association shall be retained for the payment of claims and shall not be distributed to the member insurers. Such participation by member insurers shall be in the proportion that the net direct premiums of each member insurer written for property insurance in this state during the preceding calendar year bear to the aggregate net direct premiums for property insurance of all member insurers, as reduced by any credits for voluntary writings, in this state

during the preceding calendar year. For the purposes of this subsection, the term "net direct premiums" means direct written premiums for property insurance, reduced by premium for liability coverage and for the following if included in allied lines: rain and hail on growing crops; livestock; association direct premiums booked; National Flood Insurance Program direct premiums; and similar deductions specifically authorized by the plan of operation and approved by the department. A member's participation shall begin on the first day of the calendar year following the year in which it is issued a certificate of authority to transact property insurance in the state and shall terminate 1 year after the end of the calendar year during which it no longer holds a certificate of authority to transact property insurance in the state. The commissioner, after review of annual statements, other reports, and any other statistics that the commissioner deems necessary, shall certify to the association the aggregate direct premiums written for property insurance in this state by all member insurers.

(II) Effective July 1, 2002, the association shall operate subject to the supervision and approval of a board of governors who are the same individuals that have been appointed by the Treasurer to serve on the board of governors of the Citizens Property Insurance Corporation.

(III) The plan of operation shall provide a formula whereby a company voluntarily providing windstorm coverage in affected areas will be relieved wholly or partially from apportionment of a regular assessment pursuant to sub-sub-subparagraph d.(I) or sub-sub-subparagraph d.(II).

(IV) A company which is a member of a group of companies

under common management may elect to have its credits applied on a group basis, and any company or group may elect to have its credits applied to any other company or group.

(V) There shall be no credits or relief from apportionment to a company for emergency assessments collected from its policyholders under sub-sub-subparagraph d.(III).

(VI) The plan of operation may also provide for the award of credits, for a period not to exceed 3 years, from a regular assessment pursuant to sub-sub-subparagraph d.(I) or sub-sub-subparagraph d.(II) as an incentive for taking policies out of the Residential Property and Casualty Joint Underwriting Association. In order to qualify for the exemption under this sub-sub-subparagraph, the take-out plan must provide that at least 40 percent of the policies removed from the Residential Property and Casualty Joint Underwriting Association cover risks located in Miami-Dade, Broward, and Palm Beach Counties or at least 30 percent of the policies so removed cover risks located in Miami-Dade, Broward, and Palm Beach Counties and an additional 50 percent of the policies so removed cover risks located in other coastal counties, and must also provide that no more than 15 percent of the policies so removed may exclude windstorm coverage. With the approval of the department, the association may waive these geographic criteria for a take-out plan that removes at least the lesser of 100,000 Residential Property and Casualty Joint Underwriting Association policies or 15 percent of the total number of Residential Property and Casualty Joint Underwriting Association policies, provided the governing board of the Residential Property and Casualty Joint Underwriting Association certifies that the take-out plan will

materially reduce the Residential Property and Casualty Joint Underwriting Association's 100-year probable maximum loss from hurricanes. With the approval of the department, the board may extend such credits for an additional year if the insurer guarantees an additional year of renewability for all policies removed from the Residential Property and Casualty Joint Underwriting Association, or for 2 additional years if the insurer guarantees 2 additional years of renewability for all policies removed from the Residential Property and Casualty Joint Underwriting Association.

b. Assessments to pay deficits in the association under this subparagraph shall be included as an appropriate factor in the making of rates as provided in s. 627.3512.

c. The Legislature finds that the potential for unlimited deficit assessments under this subparagraph may induce insurers to attempt to reduce their writings in the voluntary market, and that such actions would worsen the availability problems that the association was created to remedy. It is the intent of the Legislature that insurers remain fully responsible for paying regular assessments and collecting emergency assessments for any deficits of the association; however, it is also the intent of the Legislature to provide a means by which assessment liabilities may be amortized over a period of years.

d.(I) When the deficit incurred in a particular calendar year is 10 percent or less of the aggregate statewide direct written premium for property insurance for the prior calendar year for all member insurers, the association shall levy an assessment on member insurers in an amount equal to the deficit.

(II) When the deficit incurred in a particular calendar

year exceeds 10 percent of the aggregate statewide direct written premium for property insurance for the prior calendar year for all member insurers, the association shall levy an assessment on member insurers in an amount equal to the greater of 10 percent of the deficit or 10 percent of the aggregate statewide direct written premium for property insurance for the prior calendar year for member insurers. Any remaining deficit shall be recovered through emergency assessments under sub-sub-subparagraph (III).

(III) Upon a determination by the board of directors that a deficit exceeds the amount that will be recovered through regular assessments on member insurers, pursuant to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the board shall levy, after verification by the department, emergency assessments to be collected by member insurers and by underwriting associations created pursuant to this section which write property insurance, upon issuance or renewal of property insurance policies other than National Flood Insurance policies in the year or years following levy of the regular assessments. The amount of the emergency assessment collected in a particular year shall be a uniform percentage of that year's direct written premium for property insurance for all member insurers and underwriting associations, excluding National Flood Insurance policy premiums, as annually determined by the board and verified by the department. The department shall verify the arithmetic calculations involved in the board's determination within 30 days after receipt of the information on which the determination was based. Notwithstanding any other provision of law, each member insurer and each underwriting association

created pursuant to this section shall collect emergency assessments from its policyholders without such obligation being affected by any credit, limitation, exemption, or deferment. The emergency assessments so collected shall be transferred directly to the association on a periodic basis as determined by the association. The aggregate amount of emergency assessments levied under this sub-sub-subparagraph in any calendar year may not exceed the greater of 10 percent of the amount needed to cover the original deficit, plus interest, fees, commissions, required reserves, and other costs associated with financing of the original deficit, or 10 percent of the aggregate statewide direct written premium for property insurance written by member insurers and underwriting associations for the prior year, plus interest, fees, commissions, required reserves, and other costs associated with financing the original deficit. The board may pledge the proceeds of the emergency assessments under this sub-sub-subparagraph as the source of revenue for bonds, to retire any other debt incurred as a result of the deficit or events giving rise to the deficit, or in any other way that the board determines will efficiently recover the deficit. The emergency assessments under this sub-sub-subparagraph shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the payment of such bonds or other indebtedness pursuant to the document governing such bonds or other indebtedness. Emergency assessments collected under this sub-sub-subparagraph are not part of an insurer's rates, are not premium, and are not subject to premium tax, fees, or commissions; however, failure to pay

the emergency assessment shall be treated as failure to pay premium.

(IV) Each member insurer's share of the total regular assessments under sub-sub-subparagraph (I) or sub-sub-subparagraph (II) shall be in the proportion that the insurer's net direct premium for property insurance in this state, for the year preceding the assessment bears to the aggregate statewide net direct premium for property insurance of all member insurers, as reduced by any credits for voluntary writings for that year.

(V) If regular deficit assessments are made under sub-sub-subparagraph (I) or sub-sub-subparagraph (II), or by the Residential Property and Casualty Joint Underwriting Association under sub-subparagraph (6)(b)3.a. ~~or sub-subparagraph (6)(b)3.b.~~, the association shall levy upon the association's policyholders, as part of its next rate filing, or by a separate rate filing solely for this purpose, a market equalization surcharge in a percentage equal to the total amount of such regular assessments divided by the aggregate statewide direct written premium for property insurance for member insurers for the prior calendar year. Market equalization surcharges under this sub-sub-subparagraph are not considered premium and are not subject to commissions, fees, or premium taxes; however, failure to pay a market equalization surcharge shall be treated as failure to pay premium.

e. The governing body of any unit of local government, any residents of which are insured under the plan, may issue bonds as defined in s. 125.013 or s. 166.101 to fund an assistance program, in conjunction with the association, for the purpose of

defraying deficits of the association. In order to avoid needless and indiscriminate proliferation, duplication, and fragmentation of such assistance programs, any unit of local government, any residents of which are insured by the association, may provide for the payment of losses, regardless of whether or not the losses occurred within or outside of the territorial jurisdiction of the local government. Revenue bonds may not be issued until validated pursuant to chapter 75, unless a state of emergency is declared by executive order or proclamation of the Governor pursuant to s. 252.36 making such findings as are necessary to determine that it is in the best interests of, and necessary for, the protection of the public health, safety, and general welfare of residents of this state and the protection and preservation of the economic stability of insurers operating in this state, and declaring it an essential public purpose to permit certain municipalities or counties to issue bonds as will provide relief to claimants and policyholders of the association and insurers responsible for apportionment of plan losses. Any such unit of local government may enter into such contracts with the association and with any other entity created pursuant to this subsection as are necessary to carry out this paragraph. Any bonds issued under this sub-subparagraph shall be payable from and secured by moneys received by the association from assessments under this subparagraph, and assigned and pledged to or on behalf of the unit of local government for the benefit of the holders of such bonds. The funds, credit, property, and taxing power of the state or of the unit of local government shall not be pledged for the payment of such bonds. If any of the bonds remain unsold

60 days after issuance, the department shall require all insurers subject to assessment to purchase the bonds, which shall be treated as admitted assets; each insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the insurer's relative share of assessment liability under this subsection. An insurer shall not be required to purchase the bonds to the extent that the department determines that the purchase would endanger or impair the solvency of the insurer. The authority granted by this sub-subparagraph is additional to any bonding authority granted by subparagraph 6.

3. The plan shall also provide that any member with a surplus as to policyholders of $25 ~~$20~~ million or less writing 25 percent or more of its total countrywide property insurance premiums in this state may petition the department, within the first 90 days of each calendar year, to qualify as a limited apportionment company. The apportionment of such a member company in any calendar year for which it is qualified shall not exceed its gross participation, which shall not be affected by the formula for voluntary writings. In no event shall a limited apportionment company be required to participate in any apportionment of losses pursuant to sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II) in the aggregate which exceeds $50 million after payment of available plan funds in any calendar year. However, a limited apportionment company shall collect from its policyholders any emergency assessment imposed under sub-sub-subparagraph 2.d.(III). The plan shall provide that, if the department determines that any regular assessment will result in an impairment of the surplus of a limited

apportionment company, the department may direct that all or part of such assessment be deferred. However, there shall be no limitation or deferment of an emergency assessment to be collected from policyholders under sub-sub-subparagraph 2.d.(III).

4. The plan shall provide for the deferment, in whole or in part, of a regular assessment of a member insurer under sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II), but not for an emergency assessment collected from policyholders under sub-sub-subparagraph 2.d.(III), if, in the opinion of the commissioner, payment of such regular assessment would endanger or impair the solvency of the member insurer. In the event a regular assessment against a member insurer is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in sub-sub-subparagraph 2.d.(I) or sub-sub-subparagraph 2.d.(II).

5.a. The plan of operation may include deductibles and rules for classification of risks and rate modifications consistent with the objective of providing and maintaining funds sufficient to pay catastrophe losses.

b. It is the intent of the Legislature that the rates for coverage provided by the association be actuarially sound and not competitive with approved rates charged in the admitted voluntary market such that the association functions as a residual market mechanism to provide insurance only when the insurance cannot be procured in the voluntary market. The plan of operation shall provide a mechanism to assure that, beginning no later than January 1, 1999, the rates charged by the

association for each line of business are reflective of approved rates in the voluntary market for hurricane coverage for each line of business in the various areas eligible for association coverage.

c. The association shall provide for windstorm coverage on residential properties in limits up to $10 million for commercial lines residential risks and up to $1 million for personal lines residential risks. If coverage with the association is sought for a residential risk valued in excess of these limits, coverage shall be available to the risk up to the replacement cost or actual cash value of the property, at the option of the insured, if coverage for the risk cannot be located in the authorized market. The association must accept a commercial lines residential risk with limits above $10 million or a personal lines residential risk with limits above $1 million if coverage is not available in the authorized market. The association may write coverage above the limits specified in this subparagraph with or without facultative or other reinsurance coverage, as the association determines appropriate.

d. The plan of operation must provide objective criteria and procedures, approved by the department, to be uniformly applied for all applicants in determining whether an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following shall be considered:

(I) Whether the likelihood of a loss for the individual risk is substantially higher than for other risks of the same class; and

(II) Whether the uncertainty associated with the individual

risk is such that an appropriate premium cannot be determined.

The acceptance or rejection of a risk by the association pursuant to such criteria and procedures must be construed as the private placement of insurance, and the provisions of chapter 120 do not apply.

e. If the risk accepts an offer of coverage through the market assistance program or through a mechanism established by the association, either before the policy is issued by the association or during the first 30 days of coverage by the association, and the producing agent who submitted the application to the association is not currently appointed by the insurer, the insurer shall:

(I) Pay to the producing agent of record of the policy, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the association; or

(II) Offer to allow the producing agent of record of the policy to continue servicing the policy for a period of not less than 1 year and offer to pay the agent the greater of the insurer's or the association's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-subparagraph (I). Subject to the provisions of s. 627.3517, the policies issued by the association must provide that if the association obtains an offer from an authorized

insurer to cover the risk at its approved rates under either a standard policy including wind coverage or, if consistent with the insurer's underwriting rules as filed with the department, a basic policy including wind coverage, the risk is no longer eligible for coverage through the association. Upon termination of eligibility, the association shall provide written notice to the policyholder and agent of record stating that the association policy must be canceled as of 60 days after the date of the notice because of the offer of coverage from an authorized insurer. Other provisions of the insurance code relating to cancellation and notice of cancellation do not apply to actions under this sub-subparagraph.

f. When the association enters into a contractual agreement for a take-out plan, the producing agent of record of the association policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(I) Pay to the producing agent of record of the association policy, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the association; or

(II) Offer to allow the producing agent of record of the association policy to continue servicing the policy for a period of not less than 1 year and offer to pay the agent the greater of the insurer's or the association's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance

with sub-sub-subparagraph (I).

6.a. The plan of operation may authorize the formation of a private nonprofit corporation, a private nonprofit unincorporated association, a partnership, a trust, a limited liability company, or a nonprofit mutual company which may be empowered, among other things, to borrow money by issuing bonds or by incurring other indebtedness and to accumulate reserves or funds to be used for the payment of insured catastrophe losses. The plan may authorize all actions necessary to facilitate the issuance of bonds, including the pledging of assessments or other revenues.

b. Any entity created under this subsection, or any entity formed for the purposes of this subsection, may sue and be sued, may borrow money; issue bonds, notes, or debt instruments; pledge or sell assessments, market equalization surcharges and other surcharges, rights, premiums, contractual rights, projected recoveries from the Florida Hurricane Catastrophe Fund, other reinsurance recoverables, and other assets as security for such bonds, notes, or debt instruments; enter into any contracts or agreements necessary or proper to accomplish such borrowings; and take other actions necessary to carry out the purposes of this subsection. The association may issue bonds or incur other indebtedness, or have bonds issued on its behalf by a unit of local government pursuant to subparagraph (6)(q)2., in the absence of a hurricane or other weather-related event, upon a determination by the association subject to approval by the department that such action would enable it to efficiently meet the financial obligations of the association and that such financings are reasonably necessary to effectuate the

requirements of this subsection. Any such entity may accumulate reserves and retain surpluses as of the end of any association year to provide for the payment of losses incurred by the association during that year or any future year. The association shall incorporate and continue the plan of operation and articles of agreement in effect on the effective date of chapter 76-96, Laws of Florida, to the extent that it is not inconsistent with chapter 76-96, and as subsequently modified consistent with chapter 76-96. The board of directors and officers currently serving shall continue to serve until their successors are duly qualified as provided under the plan. The assets and obligations of the plan in effect immediately prior to the effective date of chapter 76-96 shall be construed to be the assets and obligations of the successor plan created herein.

c. In recognition of s. 10, Art. I of the State Constitution, prohibiting the impairment of obligations of contracts, it is the intent of the Legislature that no action be taken whose purpose is to impair any bond indenture or financing agreement or any revenue source committed by contract to such bond or other indebtedness issued or incurred by the association or any other entity created under this subsection.

7. On such coverage, an agent's remuneration shall be that amount of money payable to the agent by the terms of his or her contract with the company with which the business is placed. However, no commission will be paid on that portion of the premium which is in excess of the standard premium of that company.

8. Subject to approval by the department, the association may establish different eligibility requirements and operational

procedures for any line or type of coverage for any specified eligible area or portion of an eligible area if the board determines that such changes to the eligibility requirements and operational procedures are justified due to the voluntary market being sufficiently stable and competitive in such area or for such line or type of coverage and that consumers who, in good faith, are unable to obtain insurance through the voluntary market through ordinary methods would continue to have access to coverage from the association. When coverage is sought in connection with a real property transfer, such requirements and procedures shall not provide for an effective date of coverage later than the date of the closing of the transfer as established by the transferor, the transferee, and, if applicable, the lender.

9. Notwithstanding any other provision of law:

a. The pledge or sale of, the lien upon, and the security interest in any rights, revenues, or other assets of the association created or purported to be created pursuant to any financing documents to secure any bonds or other indebtedness of the association shall be and remain valid and enforceable, notwithstanding the commencement of and during the continuation of, and after, any rehabilitation, insolvency, liquidation, bankruptcy, receivership, conservatorship, reorganization, or similar proceeding against the association under the laws of this state or any other applicable laws.

b. No such proceeding shall relieve the association of its obligation, or otherwise affect its ability to perform its obligation, to continue to collect, or levy and collect, assessments, market equalization or other surcharges, projected

recoveries from the Florida Hurricane Catastrophe Fund, reinsurance recoverables, or any other rights, revenues, or other assets of the association pledged.

c. Each such pledge or sale of, lien upon, and security interest in, including the priority of such pledge, lien, or security interest, any such assessments, emergency assessments, market equalization or renewal surcharges, projected recoveries from the Florida Hurricane Catastrophe Fund, reinsurance recoverables, or other rights, revenues, or other assets which are collected, or levied and collected, after the commencement of and during the pendency of or after any such proceeding shall continue unaffected by such proceeding.

d. As used in this subsection, the term "financing documents" means any agreement, instrument, or other document now existing or hereafter created evidencing any bonds or other indebtedness of the association or pursuant to which any such bonds or other indebtedness has been or may be issued and pursuant to which any rights, revenues, or other assets of the association are pledged or sold to secure the repayment of such bonds or indebtedness, together with the payment of interest on such bonds or such indebtedness, or the payment of any other obligation of the association related to such bonds or indebtedness.

e. Any such pledge or sale of assessments, revenues, contract rights or other rights or assets of the association shall constitute a lien and security interest, or sale, as the case may be, that is immediately effective and attaches to such assessments, revenues, contract, or other rights or assets, whether or not imposed or collected at the time the pledge or

sale is made. Any such pledge or sale is effective, valid, binding, and enforceable against the association or other entity making such pledge or sale, and valid and binding against and superior to any competing claims or obligations owed to any other person or entity, including policyholders in this state, asserting rights in any such assessments, revenues, contract, or other rights or assets to the extent set forth in and in accordance with the terms of the pledge or sale contained in the applicable financing documents, whether or not any such person or entity has notice of such pledge or sale and without the need for any physical delivery, recordation, filing, or other action.

f. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, agents or employees of the association, members of the board of directors of the association, or the department or its representatives, for any action taken by them in the performance of their duties or responsibilities under this subsection. Such immunity does not apply to actions for breach of any contract or agreement pertaining to insurance, or any willful tort.

Section 8. Paragraph (b) of subsection (2) of section 627.4133, Florida Statutes, is amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, apartment building, or other policy covering a residential structure or

its contents:

(b) The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 ~~100~~ days before the effective date of the nonrenewal, cancellation, or termination. ~~However, the insurer shall give at least 100 days' written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November 30.~~ The notice must include the ~~reason or~~ reasons for the nonrenewal, cancellation, or termination, except that:

1. The insurer must ~~shall~~ give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 days before ~~prior to~~ the effective date of the nonrenewal, cancellation, or termination for a first-named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least the 5 years before ~~a 5-year period immediately prior to~~ the date of the written notice.

2. If cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due her or his obligations for ~~in connection with~~ the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. The term also means the failure of a

financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations are void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail.~~, and~~ If the contract is void, any premium received by the insurer from a third party must be refunded to that party in full.

3. If ~~such~~ cancellation or termination occurs during the first 90 days the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor must be given unless there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

4. After the policy has been in effect for 90 days, it may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy or unless the cancellation applies to all insureds for a given class of insureds under such policies. This subparagraph does not apply to individually rated risks having a policy term of less than 90 days.

~~4. The requirement for providing written notice by June 1 of any nonrenewal that would be effective between June 1 and November 30 does not apply to the following situations, but the insurer remains subject to the requirement to provide such notice at least 100 days before the effective date of nonrenewal:~~

~~a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground cover collapse pursuant to s. 627.706.~~

5.~~b.~~ A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement coverage to the policyholder is exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

~~After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy or if the cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks having a policy term of less than 90 days.~~

6.~~5.~~ Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy after at

least 45 days' notice if the office finds that the early cancellation of some or all of the insurer's policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer's plan for early cancellation or nonrenewal of some or all of its policies. The office may base such finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed under administrative supervision pursuant to s. 624.81 or to the appointment of a receiver under chapter 631.

7.~~6.~~ A policy covering both a home and motor vehicle may be nonrenewed for any reason applicable to ~~either~~ the property or motor vehicle insurance after providing 90 days' notice.

Section 9. Section 627.6011, Florida Statutes, is created to read:

627.6011 Mandated coverages.—Mandatory health benefits regulated under this chapter which must be covered by an insurer are intended to apply only to the type of health benefit plan defined in s. 627.6699(3), issued in any market, unless specifically designated otherwise. For purposes of this section, the term "mandatory health benefits" means those benefits set forth in ss. 627.6401-627.64193 and any cross-references to these sections, and any other mandatory treatment or health coverages or benefits enacted on or after July 1, 2012.

Section 10. Subsections (1), (2), (7), and (9) of section 627.7015, Florida Statutes, are amended to read:

627.7015 Alternative procedure for resolution of disputed property insurance claims.—

(1) ~~PURPOSE AND SCOPE.—~~This section sets forth a nonadversarial alternative dispute resolution procedure for a mediated claim resolution conference prompted by the need for effective, fair, and timely handling of property insurance claims. There is a particular need for an informal, nonthreatening forum for helping parties who elect this procedure to resolve their claims disputes because most homeowner's and commercial residential insurance policies obligate policyholders ~~insureds~~ to participate in a potentially expensive and time-consuming adversarial appraisal process before ~~prior to~~ litigation. The procedure set forth in this section is designed to bring the parties together for a mediated claims settlement conference without any of the trappings or drawbacks of an adversarial process. Before resorting to these procedures, policyholders ~~insureds~~ and insurers are encouraged to resolve claims as quickly and fairly as possible. This section is available with respect to claims under personal lines and commercial residential policies before ~~for all claimants and insurers prior to~~ commencing the appraisal process, or before commencing litigation. Mediation may be requested only by the policyholder, as a first-party claimant, or the insurer. If requested by the policyholder ~~insured~~, participation by legal counsel is ~~shall be~~ permitted. Mediation under this section is also available to litigants referred to the department by a county court or circuit court. This section does not apply to commercial coverages, to private passenger motor vehicle insurance coverages, or to disputes relating to liability coverages in policies of property insurance.

(2) At the time a first-party claim within the scope of

this section is filed by the policyholder, the insurer shall notify the policyholder ~~all first-party claimants~~ of its ~~their~~ right to participate in the mediation program under this section. The department shall prepare a consumer information pamphlet for distribution to persons participating in mediation ~~under this section~~.

(7) If the insurer fails to comply with subsection (2) by failing to notify a policyholder ~~first-party claimant~~ of its right to participate in the mediation program under this section or if the insurer requests the mediation, and the mediation results are rejected by either party, the policyholder is ~~insured shall~~ not ~~be~~ required to submit to or participate in any contractual loss appraisal process of the property loss damage as a precondition to legal action for breach of contract against the insurer for its failure to pay the policyholder's claims covered by the policy.

(9) For purposes of this section, the term "claim" refers to any dispute between an insurer and a policyholder ~~an insured~~ relating to a material issue of fact other than a dispute:

(a) With respect to which the insurer has a reasonable basis to suspect fraud;

(b) Where, based on agreed-upon facts as to the cause of loss, there is no coverage under the policy;

(c) With respect to which the insurer has a reasonable basis to believe that the policyholder ~~claimant~~ has intentionally made a material misrepresentation of fact which is relevant to the claim, and the entire request for payment of a loss has been denied on the basis of the material misrepresentation; ~~or~~

(d) With respect to which the amount in controversy is less than $500, unless the parties agree to mediate a dispute involving a lesser amount; or.

(e) Where the notice of loss is reported to the insurer more than 36 months after the declaration of a state of emergency by the Governor in response to a hurricane that makes landfall in this state.

Section 11. Subsection (4) of section 627.7295, Florida Statutes, is amended to read:

627.7295 Motor vehicle insurance contracts.—

(4) ~~If subsection (7) does not apply,~~ The insurer may cancel the policy in accordance with this code except that, notwithstanding s. 627.728, an insurer may not cancel a new policy or binder during the first 60 days immediately following the effective date of the policy or binder ~~except~~ for nonpayment of premium unless the reason for the cancellation is the issuance of a check for the premium that is dishonored for any reason or any other type of premium payment that was subsequently determined to be rejected or invalid.

Section 12. Paragraph (d) of subsection (4) of section 627.736, Florida Statutes, is amended to read:

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

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under 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 shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are

covered by the policy issued under ss. 627.730-627.7405. 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, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(d) All overdue payments ~~shall~~ bear simple interest fixed at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, in effect on the date ~~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. Interest is ~~shall be~~ due at the time payment of the overdue claim is made.

Section 13. This act shall take effect July 1, 2012.

708624

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
	.	
	.	
	.	

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 (6) is added to section 175.351, Florida Statutes, to read:

175.351 Municipalities and special fire control districts having their own pension plans for firefighters.—For any municipality, special fire control district, local law municipality, local law special fire control district, or local law plan under this chapter, in order for municipalities and special fire control districts with their own pension plans for

firefighters, or for firefighters and police officers if included, to participate in the distribution of the tax fund established pursuant to s. 175.101, local law plans must meet the minimum benefits and minimum standards set forth in this chapter.

(6) Notwithstanding any other provision, with respect to any plan established under this chapter, if the municipality or special fire control district and the plan members' collective bargaining representative or, if none, a majority of the plan members, agree to the retirement benefits provided in the plan or to the use of income from the premium tax provided pursuant to this chapter, the provisions of the agreement shall be deemed to comply with this chapter for all purposes. This subsection is retroactive in application to any agreement entered into or effective on or after October 1, 2010.

Section 2. Subsection (4) of section 185.02, Florida Statutes, is amended to read:

185.02 Definitions.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, the following words and phrases as used in this chapter shall have the following meanings, unless a different meaning is plainly required by the context:

(4) The term "compensation" or "salary" means, for noncollectively bargained service earned before July 1, 2011, or for service earned under collective bargaining agreements in place before July 1, 2011, the total cash remuneration including "overtime" paid by the primary employer to a police officer for services rendered, but not including any payments for extra duty or special detail work performed on behalf of a second party

employer. A local law plan may limit the amount of overtime payments which can be used for retirement benefit calculation purposes~~; however, such overtime limit may not be less than 300 hours per officer per calendar year~~. For noncollectively bargained service earned on or after July 1, 2011, or for service earned under collective bargaining agreements entered into on or after July 1, 2011, the term has the same meaning except that when calculating retirement benefits, up to 300 hours per year in overtime compensation may be included as specified in the plan or collective bargaining agreement, but payments for accrued unused sick or annual leave may not be included.

(a) Any retirement trust fund or plan that meets the requirements of this chapter does not, solely by virtue of this subsection, reduce or diminish the monthly retirement income otherwise payable to each police officer covered by the retirement trust fund or plan.

(b) The member's compensation or salary contributed as employee-elective salary reductions or deferrals to any salary reduction, deferred compensation, or tax-sheltered annuity program authorized under the Internal Revenue Code shall be deemed to be the compensation or salary the member would receive if he or she were not participating in such program and shall be treated as compensation for retirement purposes under this chapter.

(c) For any person who first becomes a member in any plan year beginning on or after January 1, 1996, compensation for that plan year may not include any amounts in excess of the Internal Revenue Code s. 401(a)(17) limitation, as amended by

the Omnibus Budget Reconciliation Act of 1993, which limitation of $150,000 shall be adjusted as required by federal law for qualified government plans and shall be further adjusted for changes in the cost of living in the manner provided by Internal Revenue Code s. 401(a)(17)(B). For any person who first became a member before the first plan year beginning on or after January 1, 1996, the limitation on compensation may not be less than the maximum compensation amount that was allowed to be taken into account under the plan as in effect on July 1, 1993, which limitation shall be adjusted for changes in the cost of living since 1989 in the manner provided by Internal Revenue Code s. 401(a)(17)(1991).

Section 3. Subsection (6) is added to section 185.35, Florida Statutes, to read:

185.35 Municipalities having their own pension plans for police officers.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, in order for municipalities with their own pension plans for police officers, or for police officers and firefighters if included, to participate in the distribution of the tax fund established pursuant to s. 185.08, local law plans must meet the minimum benefits and minimum standards set forth in this chapter:

(6) Notwithstanding any other provision, with respect to any plan established under this chapter, if the municipality and the plan members' collective bargaining representative or, if none, a majority of the plan members, agree to the retirement benefits provided in the plan or to the use of income from the premium tax provided pursuant to this chapter, the provisions of the agreement shall be deemed to comply with this chapter for

all purposes. This subsection is retroactive in application to any agreement entered into or effective on or after October 1, 2010.

Section 4. The Legislature finds that a proper and legitimate state purpose is served when employees and retirees of the state and its political subdivisions, and the dependents, survivors, and beneficiaries of such employees and retirees are extended the basic protections afforded by governmental retirement systems that provide fair and adequate benefits and that are managed, administered, and funded in an actuarially sound manner as required by s. 14, Art. X of the State Constitution and part VII of chapter 112, Florida Statutes. Therefore, the Legislature determines and declares that this act fulfills an important state interest.

Section 5. This act shall take effect upon becoming a law.

========== 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 public retirement plans; amending s. 175.351, F.S.; revising provisions relating to benefits paid from the premium tax by a municipality or special fire control district that has its own pension plan; providing for retroactive application; amending s. 185.02, F.S.; revising the definition of the term “compensation” or “salary” for purposes of police officers’ pensions; amending s. 185.35, F.S.;

revising provisions relating to benefits paid by a municipality that has its own pension plan; providing for retroactive application; providing a declaration of important state interest; providing an effective date.

935180

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (708624)

Delete lines 22 - 23
and insert:
members, mutually consent to the retirement benefits provided in the plan or to the use of income for retirement benefits from the premium tax provided pursuant

Delete lines 96 - 97
and insert:
none, a majority of plan members, mutually consent to the retirement benefits provided in the plan or to the use of income

935180

for retirement benefits from the

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/2012
Meeting Date

Topic Local Pension

Bill Number 910 *(if applicable)*

Name Leticia M Adams

Amendment Barcode *(if applicable)*

Job Title Director of Infrastructure & Governance Policy

Address 136 South Bronough Street
Street

Phone 850-544-6866

Tallahassee FL 32301
City *State* *Zip*

E-mail ladams@flchamber.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/2012
Meeting Date

Topic Public Employees' Pension

Bill Number 910 *(if applicable)*

Name Matt Puckett

Amendment Barcode *(if applicable)*

Job Title lobbyist

Address 300 East Brevard St.
Street

Phone 850-222-3329

Tallahassee FL 32301
City *State* *Zip*

E-mail

Speaking: ☐ For ☒ Against ☐ Information

Representing Florida Police Benevolent Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/12
Meeting Date

Topic Pensions Bill Number 910 *(if applicable)*

Name Bill Holmich Amendment Barcode *(if applicable)*

Job Title

Address 303 John Dr Phone (850) 251-3126
Street
Tallahassee FL 32301 E-mail
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Representing

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2 February 2012
Meeting Date

Topic ~~SB 910~~ Public Employees

Bill Number SB 910 *(if applicable)*

Name Jim Catron

Amendment Barcode 708624 *(if applicable)*

Job Title Mayor/Commissioner

Address 321 SW Rutledge St
Street
Madison FL 32340
City *State* *Zip*

Phone 850 673-8201

E-mail Catronj@aol.com

Speaking: [X] For [ ] Against [ ] Information

Representing Suwannee River League of Cities + City of Madison

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

_____
Meeting Date

Topic Public Employee / Pension

Bill Number 910 *(if applicable)*

Name Doug Bell

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 216 Hawk Meadow Dr
Street

Phone 222-3533

Tall FL
City *State* *Zip*

E-mail _____

Speaking: ☑ For ☐ Against ☐ Information

Representing Ormond Beach

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/2/11
Meeting Date

Topic Pension

Bill Number 910 *(if applicable)*

Name Lisa Henning

Amendment Barcode _____ *(if applicable)*

Job Title Director Legislative Affairs

Address 242 Office Plaza Dr
~~Street~~

Phone 766-8808

Tallahassee, FL 32301
City *State* *Zip*

E-mail _____

Speaking: ☐ For ☑ Against ☐ Information

Representing Fraternal Order of Police

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic _____ Bill Number SB 910 *(if applicable)*

Name Kraig Conn Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 301 S. Bronough Phone 222 9684
Street

Tall FL 32301 E-mail _____
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida League of Cities

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Public Employees — Bill Number SB 910 *(if applicable)*

Name Jerry Sansom — Amendment Barcode *(if applicable)*

Job Title

Address PO Box 98 — Phone 321-777-8138

Street

Cocoa FL 32923 — E-mail FISHAWK@AOL.COM

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Cities of Cocoa, Rockledge, Melbourne

Appearing at request of Chair: ☐ Yes ☑ No — Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic Public Emp

Bill Number 910 *(if applicable)*

Name TIM CADDELL

Amendment Barcode *(if applicable)*

Job Title Govt Relations Administrato City of Pinellas Park

Address 5851 Park Blvd
Street

Phone 727-541-0721

Pinellas Park
City *State* *Zip*

E-mail tcaddell@Pinellas-Park.com

Speaking: [X] For [ ] Against [ ] Information

Representing City of Pinellas Park

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic Local Pension Plans

Bill Number 910 *(if applicable)*

Name Jim Tolley

Amendment Barcode 935180 *(if applicable)*

Job Title Gov Relations Director

Address 345 West Madison St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850 224 7333

E-mail tolley@mindspring.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Prof Firefighters

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

2-2-12 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Municipal Retirement

Bill Number 910

Name Dean Parkerson

Amendment Barcode (if applicable) 708629

(if applicable) 935180

Job Title President

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Phone 305-525-6250

Street Miami FL 33122

E-mail deanpark@bellsouth.net

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing South Florida Council of Fire Fighters

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic MUNICIPAL RETIREMENT

Bill Number 910

Name ROBERT SUAREZ

Amendment Barcode 708624+935180 *(if applicable)*

Job Title VICE PRESIDENT, FLORIDA FIREFIGHTERS

Address 345 W. MADISON STREET
Street

Phone

TALLAHASSEE FL 33
City *State* *Zip*

E-mail

AMENDMENTS

Speaking: ☒ For ☐ Against ☐ Information

Representing FLORIDA PROFESSIONAL FIREFIGHTERS

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic Public Employees

Bill Number 910 *(if applicable)*

Name Frank Messersmith

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 2901 SE Bradford
Street

Tall FL
City *State* *Zip*

Phone 576-5858

E-mail _____

Speaking: [X] For [ ] Against [ ] Information

Representing Florida Sheriffs Assoc.

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 910

INTRODUCER: Banking and Insurance Committee and Senators Hays and Bennett

SUBJECT: Public Employees

DATE: February 3, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.			GO	
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 Division of Retirement of the Department of Management Services (DMS) is responsible for administering the Florida Retirement System and monitoring the actuarial soundness of local government retirement systems that are not part of the Florida Retirement System, as well as pension plans for firefighters and municipal police officers established in chs. 175 and 185, F.S., respectively. In addition, the DMS is responsible for approving the distribution of insurance premium tax revenues to qualified municipal police officer and firefighter pension plans.

In recent years, many state and local governments have experienced budget shortfalls and an increase in the demand for government services due to the economic downturn. This steep market decline has resulted in many governments having reduced assets available to meet future pension obligations while having increased annual required contributions for pensions.

The bill provides that, notwithstanding any plan established under chs. 175 or 185, F.S., if the local government and the plan members' collective bargaining representative or, if none, a majority of the plan members agree to the retirement benefits provided in the plan or to the use from the premium tax, the provisions of the agreement are deemed to comply with this chapter. This provision is retroactive in application to any agreement entered into or effective on or after

October 1, 2010. The bill also eliminates the requirement that a minimum of 300 hours of overtime must be included in the definition of "salary" for police officers plans under ch. 185, F.S.

This bill substantially amends the following sections of the Florida Statutes: 175.351, 185.02, and 185.35.

II. Present Situation:

Overview of State and Local Government Retirement Systems

The Division of Retirement in the Department of Management Services is responsible for monitoring Florida's state and local government defined benefit pension plans for compliance with Florida laws. However, the local boards of trustees are responsible for overseeing these local plans on a day-to-day basis. The local government plans include local pension plans under the provisions of part VII of ch. 112, F.S., and municipal police and firefighters plans established under the provisions of chs. 175 and 185, F.S., respectively.

The Municipal Police Officers' Retirement Trust Fund and the Firefighters' Pension Trust Fund are administered by a local governing board of trustees, which are created in participating cities and special fire control districts, and subject to the regulatory oversight of the Division of Retirement.[1] The membership of the board consists of five members: two residents appointed by the governing body of the municipality or a special fire control district, two police officers or firefighters selected by the active membership, and one member selected by the other four members and approved by the appropriate governing body pro forma, who are subject to two-year terms.[2]

The board of trustees has the authority to invest and reinvest pension trust fund assets into annuities and life insurance contracts in amounts sufficient to provide entitled benefits and initial and subsequent premiums.[3] Under current law, if the trust fund is not sufficient to provide entitled benefits, the municipality pays any additional contributions necessary to maintain the actuarial soundness of the plan.[4]

Actuarial Soundness and Minimum Funding Standards for Pension Plans

Article X, s. 14, of the State Constitution requires the funding of public retirement benefits on a sound actuarial basis:

> SECTION 14: State retirement systems benefit changes.- A governmental unit responsible for any retirement or pension system supported in whole or in part by public funds shall not after January 1, 1977, provide any increase in the benefits to the members

[1] Sections 175.061 and 185.05, F.S.
[2] *Id.*
[3] Sections 175.071 and 185.06, F.S.
[4] Sections 175.091(1)(d) and 185.07(1)(d), F.S.; *see also* ss. 175.051 and 185.04, F.S., stating, "[f]or any municipality, chapter plan, local law municipality, or local plan under this chapter, actuarial deficits, if any, arising under this chapter are not the obligation of the state."

> or beneficiaries of such system unless such unit has made or concurrently makes provision for the funding of the increase in benefits on a sound actuarial basis.

Part VII of ch. 112, F.S., creates minimum operation and funding standards for public employee retirement plans. It is applicable to all units of state, county, special district, and municipal governments participating in or operating a retirement system for public employees, which is funded in whole or in part by public funds.

Pursuant to ch. 112, F.S., a local government may not change retirement benefits unless the administrator of the system, prior to adoption of the change by the governing body and prior to the last public hearing thereon, has issued a statement of the actuarial impact of the proposed change upon the local retirement system and furnished a copy of such statement to the Division of Retirement in the Department of Management Services.[5] The statement also is required to indicate whether the proposed changes comply with s. 14, Art. X of the State Constitution and with s. 112.64, F.S., which relates to administration of funds and amortization of unfunded liability.

Municipal Firefighters' Pension Trust Fund and Police Officers' Retirement Trust Fund

Funding

Municipal and special district firefighters and all municipal police officers retirement trust fund systems or plans must be managed, administered, operated, and funded to maximize the protection of firefighters' and police officers' pension trust funds.[6] Funding for these pension plans comes from four sources: net proceeds from an excise tax levied by a city upon property and casualty insurance companies (known as the premium tax), employee contributions, other revenue sources, and mandatory payments by the city of any extra amount needed to keep the plan solvent. Most firefighters and police officers participate in these plans.

Each qualified insurer must pay an annual tax on specified insurance premiums received during the preceding calendar year.[7] These taxes must be paid to the Department of Revenue on March 1 of each year in an amount equal to 1.75 percent of the gross amount of receipts on the specified policies, and 1.00 percent on annuity policies or contacts, to be distributed into the General Revenue Fund. The insurer is allowed to take credits for the municipal taxes imposed on property and casualty insurance policies used to fund firefighter and police pension trust funds.[8]

The Firefighters' Pension Trust Fund is financed through an excise tax of 1.85 percent imposed on fire insurance companies, fire insurance associations, or other property insurers on the gross amount of receipts of premiums from policyholders on all premiums collected on property insurance.[9] This excise tax is imposed on the policies located within the municipality or special fire control district. It is payable to the Department of Revenue, and the net proceeds are transferred to the appropriate fund at the Division of Retirement.[10]

[5] Section 112.63, F.S.
[6] Sections 175.021(1) and 185.01(1), F.S.
[7] Section 624.509, F.S.
[8] Section 624.51055, F.S.
[9] Section 175.091(1), F.S.
[10] Section 175.121, F.S.

The Police Officers' Retirement Trust Fund is financed through an excise tax on casualty insurance policies that amount up to 0.85 percent of the gross receipts on premiums for policies issued within the municipality.[11] Similar to the Firefighters' Pension Trust Fund, the excise tax is payable to the Department of Revenue, and the net proceeds are transferred to the appropriate fund at the Division of Retirement.[12]

Benefits

Prior to the 1999 Legislative Session, the statutes contained different benefit levels for "chapter" and "local law" plans. With the amendments in 1999, all cities and districts receiving premium tax proceeds had to meet the same minimum chapter-plan benefit levels in order to be eligible for the state moneys.[13] The legislation also provided that minimum benefits could not be reduced by local charter, ordinance, resolution, or by special act of the Legislature, nor could the minimum benefits or minimum standards be reduced or offset by any other local, state, or federal law that may include firefighters or police officers in its operation, except as provided under s. 112.65, F.S.[14] [15]

Local plans were allowed to continue to use the amount of premium tax proceeds for the calendar year 1997 to fund their existing benefits, but were required to enact any missing minimum benefits as the increases in state funds became available. The law also provides that local plans in effect on October 1, 1998, must comply with the minimum benefit provisions of ch. 175 or 185, F.S., only to the extent that additional premium tax revenues become available to fund incrementally the cost of such compliance. Once a plan complies with such minimum benefit provisions, as subsequent additional premium tax revenues become available, they must be used to provide extra benefits.[16] Sections 175.351 and 185.35, F.S., define the term "extra benefits," to mean benefits in addition to or greater than those provided to general employees of the municipality, and in addition to those in existence for firefighters and police officers, respectively, on March 12, 1999.[17]

Any benefits in place on March 12, 1999, must be provided in order to maintain compliance with ch. 175 or 185, F.S., and eligibility for premium tax revenues. According to the DMS, any benefit improvements by a local plan enacted since March 12, 1999, can be reduced, or eliminated.[18] Of the 346 participating plans as of September 30, 2010, 31 have still not met all the required chapter minimum benefits, and of those, 13 are police plans that have failed to satisfy the 300 hours of overtime-minimum benefit.[19]

[11] Section 185.08, F.S.
[12] Section 185.10, F.S.
[13] Chapter 99-1, L.O.F.
[14] Sections 175.021(2) and 185.01(2), F.S.
[15] Sections 175.381 and 185.39, F.S.
[16] Section 175.351(2), F.S.
[17] Sections 175.351 and 185.02, F.S.
[18] Memorandum from Patricia Shoemaker, Division of Retirement of the Department of Management Services, to Randy Knight, City Manager of Winter Park, dated December 14, 2011.
[19] Department of Management Services SB 910 analysis, dated December 1, 2011.

III. Effect of Proposed Changes:

Section 1 amends s. 175.351, F.S., to provide that, notwithstanding any plan established under this chapter, if the municipality or special fire control district and the plan members' collective bargaining representative or, if none, a majority of the plan members mutually consent to the retirement benefits provided in the plan or to the use income for retirement benefits from premium taxes, the provisions of the agreement are deemed to comply with this chapter. This provision is retroactive in application to any agreement entered into or effective on or after October 1, 2010.

Section 2 amends s. 185.02(4), F.S., by eliminating the requirement that a minimum of 300 hours of overtime must be included in the definition of salary for police officer plans under this chapter.

Sections 3 amends ss. 185.35, F.S., to provide that, notwithstanding any plan established under this chapter, if the municipality and the plan members' collective bargaining representative or, if none, a majority of the plan members mutually consent to the retirement benefits provided in the plan or to the use from the use of income for retirement benefits from premium taxes, the provisions of the agreement are deemed to comply with this chapter. This provision is retroactive in application to any agreement entered into or effective on or after October 1, 2010.

Sections 4 provides that the act fulfills an important state interest.

Section 5 provides that the act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

To the extent this bill would require a local government to expend funds to comply with its terms, the provisions of section 18(a) of article VII of the State Constitution may apply. If those provisions do apply, in order for the law to be binding upon the cities and counties, the Legislature must find that the law fulfills an important state interest (section 4 of the bill) and one of the following relevant exceptions must apply:

- Funds estimated at the time of enactment to be sufficient to fund such expenditures are appropriated;
- Counties and cities are authorized to enact a funding source not available for such local government on February 1, 1989, that can be used to generate the amount of funds necessary to fund the expenditures;
- The expenditure is required to comply with a law that applies to all persons similarly situated; or
- The law must be approved by two-thirds of the membership of each house of the Legislature.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Indeterminate.

B. Private Sector Impact:

None.

C. Government Sector Impact:

To the extent that local governments are allowed to use premium tax revenues for more of their pension funding needs each year, there would be more revenue available to help pay these expenses.

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 Banking and Insurance on February 2, 2012:

The CS made the following changes:

- Eliminates revisions to the workers' compensation presumption under s. 112.18, F.S.
- Eliminates changes relating to the use of premium tax moneys.
- Eliminates changes to definitions of terms in chs. 175 and 185, F.S.
- Removes authority of municipalities and fire districts to establish one or more new plans, or benefit levels within a plan or to transfer all of its police and firefighters into a defined contribution plan or enroll their police and firefighters in the FRS.
- Eliminates reporting requirements

B. Amendments:

None.

By Senator Hays

20-00646A-12 2012910__

A bill to be entitled

An act relating to public employees; amending s. 112.18, F.S.; revising conditions under which certain firefighters, law enforcement officers, correctional officers, or correctional probations officers who suffer or have died from any of specified medical conditions are presumed to have been injured or killed accidentally and in the line of duty; revising the conditions under which the presumption with respect to disability due to any of specified diseases is against occurrence in the line of duty for purposes of workers' compensation claims; changing an evidentiary standard; amending s. 175.061, F.S.; providing duties of the board of trustees relating to the reporting of expenses and the operation under an administrative expense budget; amending s. 175.071, F.S.; revising requirements of the board relating to the employment of legal counsel, actuaries, and other advisers; amending s. 175.231, F.S.; providing medical conditions or behaviors that are appropriate for consideration in denying or overcoming the presumption of accidental disabilities or death suffered in the line of duty for firefighters; changing an evidentiary standard; amending s. 175.351, F.S.; revising provisions relating to benefits paid from the premium tax by a municipality or special fire control district that has its own pension plan; providing definitions; providing a process for determining the allocation of the premium tax revenues to a supplemental plan;

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amending s. 175.361, F.S.; providing certain powers and responsibilities to municipalities and special fire control districts relating to termination of plans and distribution of funds; amending s. 185.02, F.S.; revising the definition of the term "compensation" or "salary" for purposes of police officers' pensions; amending s. 185.05, F.S.; authorizing a municipality to change the municipal representation of the board of trustees pursuant to certain requirements; providing duties of the board of trustees relating to the reporting of expenses and the operation under an administrative expense budget; amending s. 185.06, F.S.; revising requirements of the board relating to the employment of legal counsel, actuaries, and other advisers; amending s. 185.34, F.S.; providing medical conditions or behaviors that are appropriate for consideration in denying or overcoming the presumption of accidental disabilities or death suffered in the line of duty for police officers; changing an evidentiary standard; amending s. 185.35, F.S.; revising provisions relating to benefits paid by a municipality that has its own pension plan; providing definitions; providing a process for determining the allocation of the premium tax revenues to a supplemental plan; amending s. 185.37, F.S.; providing certain powers and responsibilities to municipalities relating to termination of plans and distribution of funds; providing a declaration of important state interest;

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

providing an effective date.

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

Section 1. Section 112.18, Florida Statutes, is amended to read:

112.18 Firefighters and law enforcement or correctional officers; special provisions relative to disability.—

(1)(a) Any condition or impairment of health of any Florida state, municipal, county, port authority, special tax district, or fire control district firefighter or any law enforcement officer, correctional officer, or correctional probation officer as defined in s. 943.10(1), (2), or (3), who has been employed by the current employer for at least 5 years and who is less than 37 years of age, caused by tuberculosis, heart disease, or hypertension resulting in total or partial disability or death shall be presumed to have been accidental and to have been suffered in the line of duty unless the contrary be shown by a preponderance of the ~~competent~~ evidence. However, any such firefighter, correctional officer, correctional probation officer, or law enforcement officer must have successfully passed a physical examination upon entering into any such service as a firefighter, correctional officer, correctional probation officer, or law enforcement officer, which examination failed to reveal any evidence of any such condition. Risk factors and epidemiological data relating to nonwork-related conditions unique to an individual, such as blood cholesterol, body mass index, history of tobacco and alcohol use, and other medical conditions or behaviors that are associated with the

disease or condition subject to the presumption, are appropriate for consideration in denying or overcoming the presumption. Such presumption does not apply to benefits payable under or granted in a policy of life insurance or disability insurance, unless the insurer and insured have negotiated for such additional benefits to be included in the policy contract.

(b)1. For any workers' compensation claim filed under this section and chapter 440 occurring on or after July 1, 2010, a firefighter, law enforcement officer, correctional officer, or correctional probation officer as defined in s. 943.10(1), (2), or (3) suffering from tuberculosis, heart disease, or hypertension is presumed not to have incurred such disease in the line of duty as provided in this section if the firefighter, law enforcement officer, correctional officer, or correctional probation officer:

a. Departed in a material fashion from the prescribed course of treatment of his or her personal physician and the departure is demonstrated to have resulted in a significant aggravation of the tuberculosis, heart disease, or hypertension resulting in disability or increasing the disability or need for medical treatment; or

b. Was previously compensated pursuant to this section and chapter 440 for tuberculosis, heart disease, or hypertension and thereafter sustains and reports a new compensable workers' compensation claim under this section and chapter 440, and the firefighter, law enforcement officer, correctional officer, or correctional probation officer has departed in a material fashion from the prescribed course of treatment of an authorized physician for the preexisting workers' compensation claim and

the departure is demonstrated to have resulted in a significant aggravation of the tuberculosis, heart disease, or hypertension resulting in disability or increasing the disability or need for medical treatment.

2. As used in this paragraph, "prescribed course of treatment" means prescribed medical courses of action and prescribed medicines for the specific disease or diseases claimed and as documented in the prescribing physician's medical records.

3. If there is a dispute as to the appropriateness of the course of treatment prescribed by a physician under sub-subparagraph 1.a. or sub-subparagraph 1.b. or whether a departure in a material fashion from the prescribed course of treatment is demonstrated to have resulted in a significant aggravation of the tuberculosis, heart disease, or hypertension resulting in disability or increasing the disability or need for medical treatment, the firefighter, law enforcement officer, correctional officer, or correctional probation officer is entitled to seek an independent medical examination pursuant to s. 440.13(5).

4. A firefighter, law enforcement officer, correctional officer, or correctional probation officer is not entitled to the presumption provided in this section unless a claim for benefits is made prior to or within 180 days after leaving the employment of the employing agency.

(2) This section authorizes each governmental entity specified in subsection (1) to negotiate policy contracts for life and disability insurance to include accidental death benefits or double indemnity coverage which shall include the

presumption that any condition or impairment of health of any firefighter, law enforcement officer, or correctional officer caused by tuberculosis, heart disease, or hypertension resulting in total or partial disability or death was accidental and suffered in the line of duty, unless the contrary be shown by a preponderance of the ~~competent~~ evidence.

Section 2. Subsection (8) is added to section 175.061, Florida Statutes, to read:

175.061 Board of trustees; members; terms of office; meetings; legal entity; costs; attorney's fees.—For any municipality, special fire control district, chapter plan, local law municipality, local law special fire control district, or local law plan under this chapter:

(8) The board of trustees shall:

(a) Provide a detailed accounting report of its expenses for each fiscal year to the plan sponsor and the Department of Management Services and make the report available to every member of the plan. The report must include, but need not be limited to, all administrative expenses that, for purposes of this subsection, are expenses relating to any legal counsel, actuary, plan administrator, and all other consultants, and all travel and other expenses paid to or on behalf of the members of the board of trustees or anyone else on behalf of the plan.

(b) Operate under an administrative expense budget for each fiscal year, provide a copy of the budget to the plan sponsor, and make available a copy of the budget to plan members before the beginning of the fiscal year. The administrative expense budget must regulate the administrative expenses of the board of trustees. If the board of trustees amends the administrative

expense budget, the board must provide a copy of the amended budget to the plan sponsor and make available a copy of the amended budget to plan members before the amendment takes effect.

Section 3. Subsection (7) of section 175.071, Florida Statutes, is amended to read:

175.071 General powers and duties of board of trustees.—For any municipality, special fire control district, chapter plan, local law municipality, local law special fire control district, or local law plan under this chapter:

(7) To assist the board in meeting its responsibilities under this chapter, the board, if it so elects, and subject to s. 175.061(8), may:

(a) Employ independent legal counsel at the pension fund's expense.

(b) Employ an independent actuary, as defined in s. 175.032(7), at the pension fund's expense.

(c) Employ such independent professional, technical, or other advisers as it deems necessary at the pension fund's expense.

If the board chooses to use the municipality's or special district's legal counsel or actuary, or chooses to use any of the municipality's or special district's ~~other~~ professional, technical, or other advisers, it must do so only under terms and conditions acceptable to the board.

Section 4. Section 175.231, Florida Statutes, is amended to read:

175.231 Diseases of firefighters suffered in line of duty;

presumption.—For any municipality, special fire control district, chapter plan, local law municipality, local law special fire control district, or local law plan under this chapter, any condition or impairment of health of a firefighter, who has been employed by the current employer for at least 5 years and who is less than 37 years of age, caused by tuberculosis, hypertension, or heart disease resulting in total or partial disability or death shall be presumed to have been accidental and suffered in the line of duty unless the contrary is shown by a preponderance of the ~~competent~~ evidence, provided that such firefighter shall have successfully passed a physical examination before entering into such service, which examination failed to reveal any evidence of such condition. Risk factors and epidemiological data relating to nonwork-related conditions unique to an individual, such as blood cholesterol, body mass index, history of tobacco and alcohol use, and other medical conditions or behaviors that are associated with the disease or condition subject to the presumption, are appropriate for consideration in denying or overcoming the presumption. This section shall be applicable to all firefighters only with reference to pension and retirement benefits under this chapter.

Section 5. Section 175.351, Florida Statutes, is amended to read:

175.351 Municipalities and special fire control districts having their own pension plans for firefighters.—For any municipality, special fire control district, local law municipality, local law special fire control district, or local law plan under this chapter, in order for municipalities and special fire control districts with their own pension plans for

firefighters, or for firefighters and police officers if included, to participate in the distribution of the tax fund established pursuant to s. 175.101, local law plans must meet the minimum benefits and minimum standards set forth in this chapter.

(1) Notwithstanding any other provision, retirement benefits provided pursuant to this chapter and the use of the income from the premium tax in s. 175.101 must be determined and implemented in accordance with the collective bargaining process, and where collective bargaining is not applicable, in accordance with the pension plan, except as provided in subsection (2). If the term of a collective bargaining agreement ends without a new collective bargaining agreement in effect, the retirement benefits of a plan operating pursuant to this chapter shall revert to the minimum benefit provisions of this chapter for the period of time from the end of the collective bargaining agreement until the effective date of the subsequent collective bargaining agreement, and the income from the premium tax may be used for any retirement benefit provided pursuant to this chapter as determined unilaterally by the municipality or special fire control district. ~~If a municipality has a pension plan for firefighters, or a pension plan for firefighters and police officers if included, which in the opinion of the division meets the minimum benefits and minimum standards set forth in this chapter, the board of trustees of the pension plan, as approved by a majority of firefighters of the municipality, may:~~

~~(a) Place the income from the premium tax in s. 175.101 in such pension plan for the sole and exclusive use of its~~

~~firefighters, or for firefighters and police officers if included, where it shall become an integral part of that pension plan and shall be used to pay extra benefits to the firefighters included in that pension plan; or~~

~~(b) Place the income from the premium tax in s. 175.101 in a separate supplemental plan to pay extra benefits to firefighters, or to firefighters and police officers if included, participating in such separate supplemental plan.~~

(2) ~~The premium tax provided by this chapter shall in all cases be used in its entirety to provide extra benefits to firefighters, or to firefighters and police officers if included.~~ For ~~However,~~ local law plans in effect on October 1, 1998, which do not ~~must~~ comply with the minimum benefit provisions of this chapter, as ~~only to the extent that~~ additional premium tax revenues become available, such revenues shall be used to incrementally fund the cost of such compliance as provided in s. 175.162(2)(a). ~~If a plan is in compliance with such minimum benefit provisions, as subsequent additional premium tax revenues become available, they must be used to provide extra benefits.~~ Local law plans created by special act before May 27, 1939, are deemed to comply with this chapter. For the purpose of this chapter, the term~~:~~

~~(a)~~ "additional premium tax revenues" means revenues received by a municipality or special fire control district pursuant to s. 175.121 which exceed that amount received for calendar year 1997. Once a plan is in compliance with the minimum benefit provisions of this chapter, the provisions of subsection (1) apply.

~~(b) "Extra benefits" means benefits in addition to or~~

~~greater than those provided to general employees of the municipality and in addition to those in existence for firefighters on March 12, 1999.~~

(3) A retirement plan or amendment to a retirement plan may not be proposed for adoption unless the proposed plan or amendment contains an actuarial estimate of the costs involved. The ~~Such~~ proposed plan or proposed plan change may not be adopted without the approval of the municipality, special fire control district, or, if required ~~where permitted~~, the Legislature. Copies of the proposed plan or proposed plan change and the actuarial impact statement of the proposed plan or proposed plan change shall be furnished to the division before the last public hearing thereon. Such statement must also indicate whether the proposed plan or proposed plan change is in compliance with s. 14, Art. X of the State Constitution and those provisions of part VII of chapter 112 which are not expressly provided in this chapter. Notwithstanding any other provision, only those local law plans created by special act of legislation before May 27, 1939, are deemed to meet the minimum benefits and minimum standards only in this chapter.

(4) Notwithstanding any other provision, with respect to any supplemental plan municipality:

(a) A local law plan and a supplemental plan may continue to use their definition of compensation or salary in existence on March 12, 1999.

(b) Section 175.061(1)(b) does not apply, and a local law plan and a supplemental plan shall continue to be administered by a board or boards of trustees numbered, constituted, and selected as the board or boards were numbered, constituted, and

selected on December 1, 2000.

(c) The election set forth in paragraph (1)(b) is deemed to have been made.

(d) The annual amount of premium tax revenues allocated to the supplemental plan shall be determined through collective bargaining, where applicable, and in accordance with the pension plan where collective bargaining does not apply. If the term of a collective bargaining agreement ends without a new collective bargaining agreement in effect, the amount of premium tax revenues allocated to the supplemental plan shall be determined unilaterally by the municipality or special fire control district for the period of time from the end of the collective bargaining agreement until the effective date of the subsequent collective bargaining agreement.

(5) The retirement plan setting forth the benefits and the trust agreement, if any, covering the duties and responsibilities of the trustees and the regulations of the investment of funds must be in writing, and copies made available to the participants and to the general public.

(6) A municipality or special fire control district may unilaterally establish one or more new plans, or benefit levels within a plan, which provide different benefit levels for plan members based on the member's date of hire if the new plan or benefit level provides pension benefits that, in the aggregate, meet or exceed the minimum benefits set forth in this chapter, as determined by the plan's or employer's actuary. A municipality or special fire control district may unilaterally elect to maintain an existing plan and join the Florida Retirement System or establish a defined contribution retirement

plan for employees hired after a specified date. A municipality or special fire control district choosing to operate under this subsection shall use the premium tax provided under this chapter for the current plan or benefit level, for any additional plan or benefit level, for contributions to the Florida Retirement System, or for contributions to a defined contribution retirement plan.

Section 6. Section 175.361, Florida Statutes, is amended to read:

175.361 Termination of plan and distribution of fund.—For any municipality, special fire control district, chapter plan, local law municipality, local law special fire control district, or local law plan under this chapter, the plan may be terminated by the municipality or special fire control district. Upon termination of the plan by the municipality or special fire control district for any reason or because of a transfer, merger, or consolidation of governmental units, services, or functions as provided in chapter 121, or upon written notice by the municipality or special fire control district to the board of trustees that contributions under the plan are being permanently discontinued, the rights of all employees to benefits accrued to the date of such termination and the amounts credited to the employees' accounts are nonforfeitable. The fund shall be distributed in accordance with the following procedures:

(1) The board of trustees, subject to prior written approval of the municipality or special fire control district, shall determine the date of distribution and the asset value required to fund all the nonforfeitable benefits after taking

into account the expenses of such distribution. The board shall inform the municipality or special fire control district if additional assets are required, in which event the municipality or special fire control district shall continue to financially support the plan until all nonforfeitable benefits have been funded.

(2) The board of trustees, subject to prior written approval of the municipality or special fire control district, shall determine the method of distribution of the asset value, whether distribution shall be by payment in cash, by the maintenance of another or substituted trust fund, by the purchase of insured annuities, or otherwise, for each firefighter entitled to benefits under the plan as specified in subsection (3).

(3) The board of trustees, subject to prior written approval of the municipality or special fire control district, shall distribute the asset value as of the date of termination in the manner set forth in this subsection, on the basis that the amount required to provide any given retirement income is the actuarially computed single-sum value of such retirement income, except that if the method of distribution determined under subsection (2) involves the purchase of an insured annuity, the amount required to provide the given retirement income is the single premium payable for such annuity. The actuarial single-sum value may not be less than the employee's accumulated contributions to the plan, with interest if provided by the plan, less the value of any plan benefits previously paid to the employee.

(4) If there is asset value remaining after the full

distribution specified in subsection (3), and after the payment of any expenses incurred with such distribution, such excess shall be returned to the municipality or special fire control district, less return to the state of the state's contributions, provided that, if the excess is less than the total contributions made by the municipality or special fire control district and the state to date of termination of the plan, such excess shall be divided proportionately to the total contributions made by the municipality or special fire control district and the state.

(5) The board of trustees, subject to prior written approval of the municipality or special fire control district, shall distribute, in accordance with subsection (2), the amounts determined under subsection (3).

If, after 24 months after the date the plan terminated or the date the board received written notice that the contributions thereunder were being permanently discontinued, the municipality or special fire control district or the board of trustees of the firefighters' pension trust fund affected has not complied with all the provisions in this section, the Department of Management Services shall effect the termination of the fund in accordance with this section and in the manner having the least fiscal impact on the municipality or special fire control district.

Section 7. Subsection (4) of section 185.02, Florida Statutes, is amended to read:

185.02 Definitions.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, the following words and phrases as used in this chapter shall

have the following meanings, unless a different meaning is plainly required by the context:

(4) "Compensation" or "salary" means, for noncollectively bargained service earned before July 1, 2011, or for service earned under collective bargaining agreements in place before July 1, 2011, the total cash remuneration including "overtime" paid by the primary employer to a police officer for services rendered, but not including any payments for extra duty or special detail work performed on behalf of a second party employer. A local law plan may limit the amount of overtime payments which can be used for retirement benefit calculation purposes~~; however, such overtime limit may not be less than 300 hours per officer per calendar year~~. For noncollectively bargained service earned on or after July 1, 2011, or for service earned under collective bargaining agreements entered into on or after July 1, 2011, the term has the same meaning except that when calculating retirement benefits, up to 300 hours per year in overtime compensation may be included as specified in the plan or collective bargaining agreement, but payments for accrued unused sick or annual leave may not be included.

(a) Any retirement trust fund or plan that meets the requirements of this chapter does not, solely by virtue of this subsection, reduce or diminish the monthly retirement income otherwise payable to each police officer covered by the retirement trust fund or plan.

(b) The member's compensation or salary contributed as employee-elective salary reductions or deferrals to any salary reduction, deferred compensation, or tax-sheltered annuity

program authorized under the Internal Revenue Code shall be deemed to be the compensation or salary the member would receive if he or she were not participating in such program and shall be treated as compensation for retirement purposes under this chapter.

(c) For any person who first becomes a member in any plan year beginning on or after January 1, 1996, compensation for that plan year may not include any amounts in excess of the Internal Revenue Code s. 401(a)(17) limitation, as amended by the Omnibus Budget Reconciliation Act of 1993, which limitation of $150,000 shall be adjusted as required by federal law for qualified government plans and shall be further adjusted for changes in the cost of living in the manner provided by Internal Revenue Code s. 401(a)(17)(B). For any person who first became a member before the first plan year beginning on or after January 1, 1996, the limitation on compensation may not be less than the maximum compensation amount that was allowed to be taken into account under the plan as in effect on July 1, 1993, which limitation shall be adjusted for changes in the cost of living since 1989 in the manner provided by Internal Revenue Code s. 401(a)(17)(1991).

Section 8. Subsection (8) is added to section 185.05, Florida Statutes, to read:

185.05 Board of trustees; members; terms of office; meetings; legal entity; costs; attorney's fees.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter:

(8) The board of trustees shall:

(a) Provide a detailed accounting report of its expenses

for each fiscal year to the plan sponsor and the Department of Management Services and make the report available to every member of the plan. The report must include, but need not be limited to, all administrative expenses that, for purposes of this subsection, are expenses relating to any legal counsel, actuary, plan administrator, and all other consultants, and all travel and other expenses paid to or on behalf of the members of the board of trustees or anyone else on behalf of the plan.

(b) Operate under an administrative expense budget for each fiscal year, provide a copy of the budget to the plan sponsor, and make available a copy of the budget to plan members before the beginning of the fiscal year. The administrative expense budget must regulate the administrative expenses of the board of trustees. If the board of trustees amends the administrative expense budget, the board must provide a copy of the amended budget to the plan sponsor and make available a copy of the amended budget to plan members before the amendment takes effect.

Section 9. Subsection (6) of section 185.06, Florida Statutes, is amended to read:

185.06 General powers and duties of board of trustees.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter:

(6) To assist the board in meeting its responsibilities under this chapter, the board, if it so elects, and subject to s. 185.05(8), may:

(a) Employ independent legal counsel at the pension fund's expense.

(b) Employ an independent actuary, as defined in s.

185.02(8), at the pension fund's expense.

(c) Employ such independent professional, technical, or other advisers as it deems necessary at the pension fund's expense.

If the board chooses to use the municipality's or special district's legal counsel or actuary, or chooses to use any of the municipality's ~~other~~ professional, technical, or other advisers, it must do so only under terms and conditions acceptable to the board.

Section 10. Section 185.34, Florida Statutes, is amended to read:

185.34 Disability in line of duty.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, any condition or impairment of health of any ~~and all~~ police officer ~~officers~~ employed in the state, who has been employed by the current employer for at least 5 years and who is less than 37 years of age, caused by tuberculosis, hypertension, heart disease, or hardening of the arteries, resulting in total or partial disability or death, shall be presumed to be accidental and suffered in line of duty unless the contrary be shown by a preponderance of the ~~competent~~ evidence. Any condition or impairment of health caused directly or proximately by exposure, which exposure occurred in the active performance of duty at some definite time or place without willful negligence on the part of the police officer, resulting in total or partial disability, shall be presumed to be accidental and suffered in the line of duty, provided that such police officer shall have successfully passed a physical examination upon

entering such service, which physical examination including electrocardiogram failed to reveal any evidence of such condition, and, further, that such presumption shall not apply to benefits payable under or granted in a policy of life insurance or disability insurance. Risk factors and epidemiological data relating to nonwork-related conditions unique to an individual, such as blood cholesterol, body mass index, history of tobacco and alcohol use, and other medical conditions or behaviors that are associated with the disease or condition subject to the presumption, are appropriate for consideration in denying or overcoming the presumption. This section shall be applicable to all police officers only with reference to pension and retirement benefits under this chapter.

Section 11. Section 185.35, Florida Statutes, is amended to read:

185.35 Municipalities having their own pension plans for police officers.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, in order for municipalities with their own pension plans for police officers, or for police officers and firefighters if included, to participate in the distribution of the tax fund established pursuant to s. 185.08, local law plans must meet the minimum benefits and minimum standards set forth in this chapter.÷

(1) Notwithstanding any other provision, retirement benefits provided pursuant to this chapter and the use of the income from the premium tax in s. 185.08 must be determined and implemented in accordance with the collective bargaining process, and where collective bargaining is not applicable, in accordance with the pension plan, except as provided in

subsection (2). If the term of a collective bargaining agreement ends without a new collective bargaining agreement in effect, the retirement benefits of a plan operating pursuant to this chapter shall revert to the minimum benefit provisions of this chapter for the period of time from the end of the collective bargaining agreement until the effective date of the subsequent collective bargaining agreement, and the income from the premium tax may be used for any retirement benefit provided pursuant to this chapter as determined unilaterally by the municipality. ~~If a municipality has a pension plan for police officers, or for police officers and firefighters if included, which, in the opinion of the division, meets the minimum benefits and minimum standards set forth in this chapter, the board of trustees of the pension plan, as approved by a majority of police officers of the municipality, may:~~

~~(a) Place the income from the premium tax in s. 185.08 in such pension plan for the sole and exclusive use of its police officers, or its police officers and firefighters if included, where it shall become an integral part of that pension plan and shall be used to pay extra benefits to the police officers included in that pension plan; or~~

~~(b) May place the income from the premium tax in s. 185.08 in a separate supplemental plan to pay extra benefits to the police officers, or police officers and firefighters if included, participating in such separate supplemental plan.~~

(2) ~~The premium tax provided by this chapter shall in all cases be used in its entirety to provide extra benefits to police officers, or to police officers and firefighters if included.~~ For ~~However,~~ local law plans in effect on October 1,

1998, which do not ~~must~~ comply with the minimum benefit provisions of this chapter, as ~~only to the extent that~~ additional premium tax revenues become available, such revenues shall be used to incrementally fund the cost of such compliance as provided in s. 185.16(2). ~~If a plan is in compliance with such minimum benefit provisions, as subsequent additional tax revenues become available, they shall be used to provide extra benefits.~~ Local law plans created by special act before May 27, 1939, shall be deemed to comply with this chapter. For the purpose of this chapter, the term~~:~~

~~(a)~~ "additional premium tax revenues" means revenues received by a municipality pursuant to s. 185.10 which exceed the amount received for calendar year 1997. Once a plan is in compliance with the minimum benefit provisions of this chapter, the provisions of subsection (1) apply.

~~(b) "Extra benefits" means benefits in addition to or greater than those provided to general employees of the municipality and in addition to those in existence for police officers on March 12, 1999.~~

(3) A retirement plan or amendment to a retirement plan may not be proposed for adoption unless the proposed plan or amendment contains an actuarial estimate of the costs involved. The ~~Such~~ proposed plan or proposed plan change may not be adopted without the approval of the municipality or, if required ~~where permitted~~, the Legislature. Copies of the proposed plan or proposed plan change and the actuarial impact statement of the proposed plan or proposed plan change shall be furnished to the division before the last public hearing thereon. Such statement must also indicate whether the proposed plan or proposed plan

change is in compliance with s. 14, Art. X of the State Constitution and those provisions of part VII of chapter 112 which are not expressly provided in this chapter. Notwithstanding any other provision, only those local law plans created by special act of legislation before May 27, 1939, are deemed to meet the minimum benefits and minimum standards only in this chapter.

(4) Notwithstanding any other provision, with respect to any supplemental plan municipality:

(a) ~~Section 185.02(4)(a) does not apply, and~~ A local law plan and a supplemental plan may continue to use their definition of compensation or salary in existence on March 12, 1999.

(b) Section 185.05(1)(b) does not apply, and a local law plan and a supplemental plan must continue to be administered by a board or boards of trustees numbered, constituted, and selected as the board or boards were numbered, constituted, and selected on December 1, 2000.

(c) The election set forth in paragraph (1)(b) is deemed to have been made.

(d) The annual amount of premium tax revenues allocated to the supplemental plan shall be determined through collective bargaining, where applicable, and in accordance with the pension plan where collective bargaining does not apply. If the term of a collective bargaining agreement ends without a new collective bargaining agreement in effect, the amount of premium tax revenues allocated to the supplemental plan shall be determined unilaterally by the municipality for the period of time from the end of the collective bargaining agreement until the effective

date of the subsequent collective bargaining agreement.

(5) The retirement plan setting forth the benefits and the trust agreement, if any, covering the duties and responsibilities of the trustees and the regulations of the investment of funds must be in writing and copies made available to the participants and to the general public.

(6) A municipality may unilaterally establish one or more new plans, or benefit levels within a plan, which provide different benefit levels for plan members based on the member's date of hire if the new plan or benefit level provides pension benefits that, in the aggregate, meet or exceed the minimum benefits set forth in this chapter, as determined by the plan's or employer's actuary. A municipality may unilaterally elect to maintain an existing plan and join the Florida Retirement System or establish a defined contribution retirement plan for employees hired after a specified date. A municipality choosing to operate under this subsection shall use the premium tax provided under this chapter for the current plan or benefit level, for any additional plan or benefit level, for contributions to the Florida Retirement System, or for contributions to a defined contribution retirement plan.

Section 12. Section 185.37, Florida Statutes, is amended to read:

185.37 Termination of plan and distribution of fund.—For any municipality, chapter plan, local law municipality, or local law plan under this chapter, the plan may be terminated by the municipality. Upon termination of the plan by the municipality for any reason, or because of a transfer, merger, or consolidation of governmental units, services, or functions as

provided in chapter 121, or upon written notice to the board of trustees by the municipality that contributions under the plan are being permanently discontinued, the rights of all employees to benefits accrued to the date of such termination or discontinuance and the amounts credited to the employees' accounts are nonforfeitable. The fund shall be distributed in accordance with the following procedures:

(1) The board of trustees, subject to prior written approval of the municipality, shall determine the date of distribution and the asset value required to fund all the nonforfeitable benefits, after taking into account the expenses of such distribution. The board shall inform the municipality if additional assets are required, in which event the municipality shall continue to financially support the plan until all nonforfeitable benefits have been funded.

(2) The board of trustees, subject to prior written approval of the municipality, shall determine the method of distribution of the asset value, whether distribution shall be by payment in cash, by the maintenance of another or substituted trust fund, by the purchase of insured annuities, or otherwise, for each police officer entitled to benefits under the plan, as specified in subsection (3).

(3) The board of trustees, subject to prior written approval of the municipality, shall distribute the asset value as of the date of termination in the manner set forth in this subsection, on the basis that the amount required to provide any given retirement income is the actuarially computed single-sum value of such retirement income, except that if the method of distribution determined under subsection (2) involves the

purchase of an insured annuity, the amount required to provide the given retirement income is the single premium payable for such annuity. The actuarial single-sum value may not be less than the employee's accumulated contributions to the plan, with interest if provided by the plan, less the value of any plan benefits previously paid to the employee.

(4) If there is asset value remaining after the full distribution specified in subsection (3), and after payment of any expenses incurred with such distribution, such excess shall be returned to the municipality, less return to the state of the state's contributions, provided that, if the excess is less than the total contributions made by the municipality and the state to date of termination of the plan, such excess shall be divided proportionately to the total contributions made by the municipality and the state.

(5) The board of trustees, subject to prior written approval of the municipality, shall distribute, in accordance with the manner of distribution determined under subsection (2), the amounts determined under subsection (3).

If, after 24 months after the date the plan terminated or the date the board received written notice that the contributions thereunder were being permanently discontinued, the municipality or the board of trustees of the municipal police officers' retirement trust fund affected has not complied with all the provisions in this section, the Department of Management Services shall effect the termination of the fund in accordance with this section and in the manner having the least fiscal impact on the municipality.

Section 13. The Legislature finds that a proper and legitimate state purpose is served when employees and retirees of the state and its political subdivisions, and the dependents, survivors, and beneficiaries of such employees and retirees are extended the basic protections afforded by governmental retirement systems that provide fair and adequate benefits and that are managed, administered, and funded in an actuarially sound manner as required by s. 14, Article X of the State Constitution and part VII of chapter 112, Florida Statutes. Therefore, the Legislature determines and declares that this act fulfills an important state interest.

Section 14. This act shall take effect July 1, 2012.

144930

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 15 - 20
and insert:
(8) Upon expiration of the policy term, an insurer may transfer a commercial lines policy to another authorized insurer that is a member of the same group or owned by the same holding company as the transferring insurer. The transfer constitutes a renewal of the policy and may not be treated as a cancellation or a nonrenewal of the policy. The insurer must provide notice of its intent to transfer the policy at least 45 days before the effective date of the transfer along with the financial rating

144930

of the authorized insurer to which the policy is being transferred. Such notice may be provided in the notice of renewal premium. This subsection does not apply to a policy providing residential property insurance coverage, except for farmowners insurance and commercial general liability policies providing farm coverage or commercial property policies providing farm coverage.

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

And the title is amended as follows:

Delete line 6

and insert:

rather than a cancellation or nonrenewal; requiring notice of such transfer; specifying which types of policies such transfer provisions apply to; providing an

2-2-2012

SB 1428

Meeting Date

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Topic transfer of commercial polices

Bill Number SB 1428 *(if applicable)*

Name Meredith Snowden

Amendment Barcode _____ *(if applicable)*

Job Title consultant

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Tall 32301
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Speaking: ☑ For ☐ Against ☐ Information

Representing FCCI Insurance Group

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 1428
INTRODUCER:	Banking and Insurance Committee and Senator Smith
SUBJECT:	Renewal of a Commercial Lines Insurance Policy
DATE:	February 2, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.			BC	
3.				
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 upon the expiration of the term of a commercial lines insurance policy, the insurer may transfer the policy to another authorized insurer that is a member of the same group or owned by the same holding company. This type of transfer would be treated as a renewal of the policy, rather than a cancellation or nonrenewal. The insurer is required to provide at least 45 days' notice of its intent to transfer, along with the financial rating of the insurer to which the policy is being transferred. The notice may be provided in the notice of renewal premium.

The bill explicitly provides that it does not apply to residential property insurance, except for farmowners insurance and general liability policies that provide farm coverage or commercial property policies that provide farm coverage.

This bill substantially amends the following section of the Florida Statutes: 627.4133.

II. Present Situation:

Commercial Lines Insurance

Commercial lines insurance is designed for and purchased by businesses to cover losses sustained by the business.[1] The specific type of commercial lines insurance that a business purchases may depend, in part, on the business type and industry. Major types of commercial insurance are:

- Boiler and machinery;
- Business income;
- Commercial automobile;
- Comprehensive general liability;
- Directors and officers liability;
- Medical malpractice liability;
- Product liability;
- Professional liability; and
- Workers' compensation.

Notice of Cancellation, Nonrenewal, or Renewal Premium

The requirements for an insurer to give notice of cancellation, nonrenewal, or renewal premium are provided in s. 627.4133, F.S. The specific notice depends on the type of insurance being provided and the particular circumstances of the subject policy. For workers' compensation, employer's liability insurance, property (except personal lines and commercial lines residential), casualty except mortgage guaranty, surety, or marine insurance, other than motor vehicle, must give the insured at least 45 days' written notice of cancellation, nonrenewal, or the renewal premium.[2] For motor vehicle policies, the general requirement is also 45 days notice for nonrenewal or cancellation, but there exist several exceptions, depending on the circumstance.[3] For personal lines or commercial lines residential property insurance:

- Generally, an insurer must give the insured 100 days written notice of nonrenewal or cancellation, and must give 45 days' notice of the renewal premium;[4]
- For any nonrenewal or cancellation that would be effective between June 1 and November 30 (hurricane season), an insurer must give notice by June 1, or 100 days, whichever is earlier;[5]
- If the nonrenewal or cancellation would be effective between June 1 and November 30, but the reason is a revision in sinkhole coverage, the insurer must give the insured 100 days written notice of nonrenewal;[6]
- If the nonrenewal or cancellation would be effective between June 1 and November 30, but the policy is to be nonrenewed by Citizens pursuant to an approved assumption plan by an authorized insurer, Citizens must give the insured 45 days written notice of nonrenewal;[7]

[1] http:/www2.iii.org/glossary/ "commercial lines" definition. Last visited 1/23/2012.
[2] Section 627.4133(1)(a) and (b), F.S.
[3] Section 627.728(3) and (4), F.S.
[4] Section 627.4133(2)(a) and (b), F.S.
[5] Section 627.4133(2)(b), F.S.
[6] Section 627.4133(2)(b)1., F.S.
[7] Section 627.4133(2)(b)4.b., F.S.

- If the insured structure has been insured by the insurer or an affiliate for at least 5 years, the insurer must give 120 days' notice of nonrenewal or cancellation;[8]
- If the cancellation is for nonpayment of premium, the insurer must give 10 days' notice of cancellation accompanied by the reason for the cancellation;[9]
- If the OIR finds that the early cancellation is necessary to protect the best interests of the public or policyholders, the insurer must give the insured 45 days written notice of cancellation or nonrenewal.[10]

Section 627.728(4)(d), F.S.

Currently, s. 627.728(4)(d), F.S., allows an insurance company to transfer a motor vehicle insurance policy to a new insurer under the same ownership or management of first insurer, instead of canceling and nonrenewing the policies at the expiration of the policy term, by giving the insured 45 days' advance notice the intent to transfer.

III. Effect of Proposed Changes:

The bill provides that upon the expiration of the term of a commercial lines insurance policy, the insurer may transfer the policy to another authorized insurer that is a member of the same group or owned by the same holding company. This type of transfer would be treated as a renewal of the policy, rather than a cancellation or nonrenewal. The insurer is required to provide at least 45 days' notice of its intent to transfer, along with the financial rating of the insurer to which the policy is being transferred. The notice may be provided in the notice of renewal premium.

The bill explicitly provides that it does not apply to residential property insurance, except for farmowners insurance and general liability policies that provide farm coverage or commercial property policies that provide farm coverage.

The bill is effective upon becoming a law.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[8] Section 627.4133(2)(b)1., F.S.
[9] Section 627.4133(1)(b)1., F.S.
[10] Section 627.4133(2)(b)5., F.S.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Allowing policies to be transferred between affiliated insurers, rather than requiring policies to be nonrenewed by the original insurer and reissued by an affiliated insurer, allows insurers to more easily manage their book of business, and insurers believe it will eliminate confusion among policyholders associated with policy nonrenewal and subsequent reissuance.

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 Banking and Insurance on February 2, 2012:

The CS provides that upon the expiration of the term of a commercial lines insurance policy, the insurer may transfer the policy to another authorized insurer that is a member of the same group or owned by the same holding company, whereas the original bill allowed a transfer to an authorized insurer under the "same direct or indirect ownership, management, or control" as the original insurer.

The CS adds the requirement that the insurer must provide at least 45 days' notice of its intent to transfer, along with the financial rating of the insurer to which the policy is being transferred. The CS allows the insurer to provide the notice of its intent to transfer within the notice of renewal premium.

The CS explicitly provides that it does not apply to residential property insurance, except for farmowners insurance and general liability policies that provide farm coverage or commercial property policies that provide farm coverage.

B. Amendments:

None.

By Senator Smith

29-00829A-12 20121428__

A bill to be entitled

An act relating to the renewal of a commercial lines insurance policy; amending s. 627.4133, F.S.; providing that the transfer of a policy to certain other insurers is considered a renewal of the policy rather than a cancellation or nonrenewal; providing an effective date.

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

Section 1. Subsection (8) is added to section 627.4133, Florida Statutes, to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(8) Upon the expiration of the term of a commercial lines policy, the insurer may transfer such policy to another authorized insurer under the same direct or indirect ownership, management, or control as the transferring insurer. Such transfer shall be treated as a renewal of the policy and not a cancellation or nonrenewal of the policy.

Section 2. This act shall take effect upon becoming a law.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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 1814
INTRODUCER:	Senator Smith
SUBJECT:	Uniform Home Grading Scale
DATE:	January 30, 2012
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rubio	Burgess	BI	**Favorable**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

Current s. 215.55865, F.S., required that by 2007, the Financial Services Commission (Commission) was to adopt a uniform home grading scale to grade the ability of a home to withstand the wind load from a tropical storm or hurricane. Consistent with that statutory requirement, the Commission adopted the uniform home grading scale in 2007. Subsequent to the development of the uniform home grading scale, the legislature established three specific applications for which the uniform home grading scale was required to be used. More recently, however, the Legislature has repealed each of these three applications.

The bill repeals the language requiring the Financial Services Commission to develop a uniform home grading scale by 2007.

The bill also removes from the My Safe Florida Home Program (MSFH) a requirement that MSFH create a hurricane resistance rating scale that conforms to the uniform home grading scale. Because all funds originally appropriated to the program have been exhausted, MSFH is no longer operative.

This bill substantially amends the following section of the Florida Statutes: 215.5586

This bill repeals the following section of the Florida Statutes: 215.55865

II. Present Situation:

Uniform Home Grading Scale

In 2006, the Legislature required the Office of Insurance Regulation (OIR) to develop a program to provide an objective rating system allowing homeowners to evaluate the relative ability of Florida properties to withstand the wind load from a sustained severe tropical storm or hurricane.[1] In 2007, the Legislature created current s. 215.55865, F.S., requiring that by 2007, the Financial Services Commission (Commission) was to adopt a uniform home grading scale consistent with the 2006 legislation.[2] In 2007, pursuant to the statutory requirement, the Commission adopted the uniform home grading scale.[3] The uniform home grading scale scores homes on a scale of 1 to 100 and takes into account the construction features of the home, the home's wind zone location, and the terrain surrounding the home. In evaluating the home, eight primary wind resistive building features are considered: roof shape, secondary water resistance, roof cover, roof deck attachment, roof-to-wall connection, opening protection, number of stories, and roof covering type. Eleven secondary factors are also considered.

In 2008, the Legislature passed a law that established a two-part phase-in of a requirement that sellers of homes located in the state's wind borne debris region disclose the home's windstorm mitigation rating based on the home grading scale to prospective purchasers:

- The first part of the phase-in was to begin in January 2010, and would have required sellers of homes insured by Citizens Property Insurance Corporation for $500,000 or more to disclose the home's windstorm mitigation rating.[4] However, in 2009, before it took effect, this disclosure requirement was repealed.[5]
- The second part of the phase-in, which was scheduled to begin on January 1, 2011, would have required sellers of any home in the wind borne debris region to disclose to the purchaser the home's mitigation rating.[6] In 2010, however the Legislature repealed this disclosure provision, as well.[7]

In addition, in 2008, the Legislature passed s. 627.0629(1)(b), F.S.,[8] which required the OIR to develop a method by February 1, 2011, to establish mitigation discounts for hurricane mitigation measures that correlate to the home's rating calculated by the uniform home grading scale. At that time, the OIR had already been enforcing an existing statutory requirement that property insurers provide discounts for hurricane loss mitigation, but because OIR's established discounts pre-dated the uniform home grading scale, those discounts did not directly correlate to the uniform home grading scale. In 2011, the Legislature repealed s. 627.0629(1)(b), F.S.,[9] thereby removing the requirement that the OIR establish a new wind mitigation discount scale to correlate with the uniform home grading scale.

[1] Section 39, ch. 2006-12, L.O.F.
[2] Section 40, ch. 2007-1, L.O.F.
[3] Rule 69O-167.015, F.A.C.
[4] Section 13, ch. 2008-66, L.O.F.
[5] Section 10, ch. 2009-87, L.O.F.
[6] Section 15, ch. 2008-66, L.O.F.
[7] Section 1, ch. 2010-275, L.O.F.
[8] Section 12, ch. 2008-66, L.O.F.
[9] Section 14, ch. 2011-39, L.O.F.

My Safe Florida Home

Section 215.5586, F.S., established within the Department of Financial Services (DFS) the My Safe Florida Home Program (MSFH), which was created to provide Florida residential property owners with mitigation inspections and grants for installation of specified mitigation features in order to make property less vulnerable to hurricane damage. The inspections provided to homeowners under the MSFH program must at a minimum include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.
2. A range of cost estimates regarding the recommended mitigation improvements.
3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.
4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities. The statute directs that, as soon as practical, this rating scale must conform to the uniform home grading scale, under s. 215.55865, F,S.[10]

The MSFH program expired on June 30, 2009, and is no longer operative. All funds originally appropriated to the program were exhausted and no additional funding has been appropriated.[11]

III. Effect of Proposed Changes:

Section 1 repeals s. 215.55865, F.S., relating to the uniform home grading scale. This section required the Commission to develop the uniform home grading scale by 2007. The uniform home grading scale was timely developed by the Commission. There is nothing in current law that requires the use of the uniform home grading scale.

Section 2 amends s. 215.5586, F.S., to remove the requirement that the MSFH program adopt a hurricane resistance rating scale that conforms to the uniform home grading scale.

The act is effective July 1, 2012.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[10] Section 215.5586(1)(a), F.S.
[11] My Safe Florida Home website, http://www.mysafefloridahome.com (last viewed January 27, 2012).

C. Trust Funds Restrictions:

None.

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.

By Senator Smith

29-01265-12 20121814__

A bill to be entitled

An act relating to a uniform home grading scale; repealing s. 215.55865, F.S., relating to the required adoption by the Financial Services Commission of a uniform home grading scale to grade the ability of a home to withstand the wind load from certain tropical storms or hurricanes; amending s. 215.5586, F.S., to conform; providing an effective date.

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

Section 1. Section 215.55865, Florida Statutes, is repealed.

Section 2. Paragraph (a) of subsection (1) of section 215.5586, Florida Statutes, is amended to read:

215.5586 My Safe Florida Home Program.—There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Home Program provide trained and certified inspectors to perform inspections for owners of site-built, single-family, residential properties and grants to eligible applicants as funding allows. The program shall develop and implement a comprehensive and

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coordinated approach for hurricane damage mitigation that may include the following:

(1) HURRICANE MITIGATION INSPECTIONS.—

(a) Certified inspectors to provide home-retrofit inspections of site-built, single-family, residential property may be offered to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. The Department of Financial Services shall contract with wind certification entities to provide hurricane mitigation inspections. The inspections provided to homeowners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the recommended mitigation improvements.

3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

~~4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities. As soon as practical, the rating scale must be the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865.~~

Section 3. This act shall take effect July 1, 2012.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraphs (a) and (i) of subsection (7) of section 11.45, Florida Statutes, are amended to read:

11.45 Definitions; duties; authorities; reports; rules.—

(7) AUDITOR GENERAL REPORTING REQUIREMENTS.—

(a) The Auditor General must ~~shall~~ notify the Legislative Auditing Committee of any local governmental entity, district school board, charter school, or charter technical career center that does not comply with the reporting requirements of s.

215.985 or s. 218.39.

(i) Beginning in 2012, the Auditor General shall annually transmit by July 15, to the President of the Senate, the Speaker of the House of Representatives, and the Department of Financial Services, a list of all school districts, charter schools, charter technical career centers, Florida College System institutions, state universities, and water management districts that have failed to comply with the transparency requirements of s. 215.985 as identified in the audit reports reviewed pursuant to paragraph (b) and those conducted pursuant to subsection (2).

Section 2. Section 215.971, Florida Statutes, is amended to read:

215.971 Agreements funded with federal and state assistance.—

(1) For an agency agreement that provides state financial assistance to a recipient or subrecipient, as those terms are defined in s. 215.97, or that provides federal financial assistance to a subrecipient, as defined by applicable United States Office of Management and Budget circulars, the agreement must ~~shall~~ include a provision:

(a) ~~(1) A provision~~ Specifying a scope of work that clearly establishes the tasks that the recipient or subrecipient is required to perform; and

(b) ~~(2) A provision~~ Dividing the agreement into quantifiable units of deliverables which ~~that~~ must be received and accepted in writing by the agency before payment. Each deliverable must be directly related to the scope of work and ~~must~~ specify a performance measure. As used in this paragraph, the term "performance measure" means the required minimum level of

service to be performed and the criteria for evaluating the successful completion of each deliverable.

(2) Effective October 1, 2012, before execution, agreements to be funded with state or federal financial assistance must be submitted for review and approval in accordance with rules adopted by the Department of Financial Services. The review must ensure that the agreement document contains a clear statement of work, quantifiable and measureable deliverables, performance measures, and financial consequences for nonperformance. An agreement that does not comply with this subsection may be rejected and returned to the submitting agency for revision.

(3) The Chief Financial Officer may establish dollar thresholds and other criteria for sampling the agreements that are to be reviewed prior to execution. The Chief Financial Officer may revise such thresholds and other criteria for an agency or the unit of any agency as he or she deems appropriate.

(4) The department has 30 days to make a final determination regarding approval of an agreement. The department and the agency entering into the agreement may agree to a longer review period to ensure the thorough consideration of the procurement process and its results.

(5) For each agreement funded with federal or state assistance, the contracting agency shall designate an employee to function as grant manager who shall be responsible for enforcing performance of the agreement terms and conditions and serve as a liaison with the recipient. A grant manager who is responsible for one or more agreements in excess of the threshold amount provided in s. 287.017 for CATEGORY FIVE must be certified under s. 287.1312. The Chief Financial Officer

shall establish and disseminate uniform procedures for payment requests pursuant to s. 17.03(3) to ensure that services are rendered in accordance with the agreement terms before the agency processes an invoice for payment. The procedures must include, but need not be limited to, procedures for monitoring and documenting a recipient's performance, reviewing and documenting all deliverables for which payment is requested by the recipient, and providing written certification by the grant manager of the agency's receipt of goods and services.

Section 3. Subsection (16) of section 215.985, Florida Statutes, is amended to read:

215.985 Transparency in government spending.—

(16) The Chief Financial Officer shall establish and maintain a secure, shared, intergovernmental contract tracking ~~provide public access to a state contract management~~ system.

(a) Within 30 calendar days after executing a contract, each state agency as defined in s. 216.011(1), and, effective November 1, 2013, each local governmental entity and independent special district as defined in s. 218.31, each district school board as described in s. 1001.32, the Board of Governors of the State University System as described in s. 1001.70, and each Florida College System institution board of trustees as described in s. 1001.61 must post the following ~~that provides~~ information and documentation relating to that contract on the contract tracking system: ~~contracts procured by governmental entities.~~

1. The name of the contracting entities;

2. The procurement method;

3. The contract beginning and ending dates;


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4. The nature or type of the commodities or services purchased;

5. Applicable contract unit prices and deliverables;

6. Total compensation to be paid or received under the contract;

7. All payments made to the contract vendor to date;

8. All commodities or services received from the contract vendor to date;

9. Applicable contract performance measures;

10. Contract extensions or renewals, if any;

11. The justification for not using competitive solicitation to procure the contract, including citation to any statutory exemption or exception from competitive solicitation, if applicable;

12. Electronic copies of the contract and procurement documents, including any provision that may have been redacted to conceal exempt or confidential information; and

13. Any other information regarding the contract or the procurement which may be required by the Department of Financial Services.

~~(a) The data collected in the system must include, but need not be limited to, the contracting agency; the procurement method; the contract beginning and ending dates; the type of commodity or service; the purpose of the commodity or service; the compensation to be paid; compliance information, such as performance metrics for the service or commodity; contract violations; the number of extensions or renewals; and the statutory authority for providing the service.~~

(b) Within 30 calendar days after a major modification or

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amendment ~~change~~ to an existing contract, ~~or the execution of a new contract, agency procurement staff of~~ the affected ~~state governmental~~ entity must ~~shall~~ update the ~~necessary~~ information described in paragraph (a) in the ~~state~~ contract tracking ~~management~~ system. A major modification or amendment ~~change~~ to a contract includes, but is not limited to, a renewal, termination, or extension of the contract, or an amendment to the contract as determined by the Chief Financial Officer.

(c) Each entity identified in paragraph (a) must redact, as defined in s. 119.011, any exempt or confidential information, including trade secrets as defined in s. 688.002 or s. 812.081, from the contract or procurement documents before posting an electronic copy of such documents on the contract tracking system.

1. If an entity becomes aware that an electronic copy of a contract or procurement document that it posted has not been properly redacted, the entity must replace the electronic copy of the documents with a redacted copy.

2. If a party to a contract, or an authorized representative thereof, discovers that an electronic copy of a contract or procurement document on the system has not been properly redacted, the party or representative may request the entity that posted the document to redact the exempt or confidential information. Upon receipt of a request in compliance with this subparagraph, the entity that posted the document shall redact the exempt or confidential information.

a. Such request must be in writing and delivered by mail, facsimile, or electronic transmission, or in person to the entity that posted the information. The request must identify

the specific document, the page numbers that include the exempt or confidential information, the information that is exempt or confidential, and the relevant statutory exemption. A fee may not be charged for a redaction made pursuant to such request.

b. If necessary, a party to the contract may petition the circuit court for an order directing compliance with this paragraph.

3. The Chief Financial Officer, the Department of Financial Services, or any officer, employee, or contractor thereof, is not responsible for redacting exempt or confidential information from an electronic copy of a contract or procurement document posted by another entity on the system, and is not liable for the failure of the entity to redact the exempt or confidential information. The Department of Financial Services may notify the posting entity if it discovers that a document posted on the tracking system contains exempt or confidential information.

(d) Pursuant to ss. 119.01 and 119.07, the Chief Financial Officer may make information posted on the contract tracking system available for viewing and downloading by the public through a secure website. Unless otherwise provided by law, information retrieved electronically pursuant to this paragraph is not admissible in court as an authenticated document.

1. The Chief Financial Officer may regulate and prohibit the posting of records that could facilitate identity theft or fraud, such as signatures; compromise or reveal an agency investigation; reveal the identity of undercover personnel; reveal proprietary confidential business information or trade secrets; reveal an individual’s medical information; or reveal any other record or information that the Chief Financial Officer

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believes may jeopardize the health, safety, or welfare of the public. However, such prohibition does not eliminate the duty of an entity to provide a copy of a public record upon request. The Chief Financial Officer shall use appropriate Internet security measures to ensure that no person has the ability to alter or modify records available on the website.

2. Records made available on the website, including electronic copies of contracts or procurement documents, may not reveal information made exempt or confidential by law. Notice of the right of an affected party to request redaction of exempt or confidential information pursuant to paragraph (c) must be conspicuously and clearly displayed on the website. This includes, but is not limited to:

a. Criminal intelligence or criminal investigative information as defined in s. 119.011;

b. Surveillance techniques or procedures or personnel;

c. The identity of a confidential informant or confidential source;

d. The identify of undercover personnel of a criminal justice agency;

e. A security system plan; or

f. Trade secret as defined in s. 688.002 or s. 812.081.

(e) The posting of information on the contract tracking system or the provision of contract information on a website for public viewing and downloading does not eliminate the duty of an entity to respond to a public record request for such information or to a subpoena for such information.

1. A request for a copy of a contract or procurement document or a certified copy of a contract or procurement


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document shall be made to the entity that is party to the contract and that maintains the original documents. Such request may not be made to the Chief Financial Officer or the Department of Financial Services or any officer, employee, or contractor thereof unless the Chief Financial Officer or the department is a party to the contract.

2. A subpoena for a copy of a contract or procurement document or certified copy of a contract or procurement document must be served on the entity that is a party to the contract and that maintains the original documents. The Chief Financial Officer or the Department of Financial Services or any officer, employee, or contractor thereof may not be served a subpoena for those records unless the Chief Financial Officer or the department is a party to the contract.

(f) The Department of Financial Services may adopt rules to administer this subsection.

Section 4. Section 216.0111, Florida Statutes, is repealed.

Section 5. Effective October 1, 2013, section 287.032, Florida Statutes, is amended to read:

287.032 Departmental responsibility ~~purpose of department~~.~~—~~ Pursuant to the administration of this chapter:

(1) ~~It shall be~~ The responsibility ~~purpose~~ of the Department of Management Services is to:

(a)~~(1)~~ ~~To~~ Promote efficiency, economy, and the conservation of energy and coordinate ~~to effect coordination in~~ the purchase of commodities and contractual services for the state.

~~(2) To provide uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users.~~


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(b) ~~(3) To~~ Procure and distribute federal surplus tangible personal property allocated to the state by the Federal Government.

(2) The responsibility of the Department of Financial Services is to:

(a) Provide uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users.

(b) Monitor agencies with respect to compliance with established policies, rules, and procedures.

Section 6. Effective October 1, 2013, section 287.042, Florida Statutes, is amended to read:

287.042 Powers, duties, and functions of the Department of Management Services.—The department is responsible for the procurement of commodities and contractual services for agencies and has ~~shall have~~ the following powers, duties, and functions:

(1) ~~(a)~~ To canvass all sources of supply, establish and maintain a vendor list, and contract for the purchase, lease, or acquisition, including purchase by installment sales or lease-purchase contracts which may provide for the payment of interest on unpaid portions of the purchase price, of all commodities and contractual services required by an ~~any~~ agency under this chapter. A ~~Any~~ contract providing for deferred payments and the payment of interest is ~~shall be~~ subject to specific rules adopted by the Department of Financial Services.

(a) ~~(b)~~ The department shall develop a list of interested vendors to be maintained by classes of commodities and contractual services. The list may not be used to prequalify a vendor or to exclude an interested vendor from bidding. However,


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a vendor barred by the Chief Financial Officer pursuant to s. 287.044(7) may not be included on the list. The department may remove from the ~~its~~ vendor list any source of supply which fails to fulfill any of its duties specified in a contract with the state. The department ~~It~~ may reinstate ~~any~~ such source of supply if the department ~~when it~~ is satisfied that further instances of default will not occur.

(b) ~~(c)~~ In order to promote the cost-effective procurement of commodities and contractual services, the department or an agency may enter into contracts that limit the liability of a vendor consistent with s. 672.719.

~~(d) The department shall issue commodity numbers for all products of the corporation operating the correctional industry program which meet or exceed department specifications.~~

(c) ~~(e)~~ The department shall include the products offered by the corporation operating the correctional industry program on any listing prepared by the department which lists state term contracts executed by the department. The products or services shall be placed on such list in a category based upon specification criteria developed through a joint effort of the department and the corporation and approved by the department.

1. ~~(f)~~ The corporation may submit products and services to the department for testing, analysis, and review relating to the quality and cost comparability. If, after review and testing, the department approves ~~of~~ the products and services, the department shall give written notice ~~thereof~~ to the corporation. The corporation shall pay a reasonable fee ~~charged~~ for the testing of its products by the Department of Agriculture and Consumer Services.


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2. The department shall issue a commodity number for all products of the corporation which meet or exceed department specifications.

(d) ~~(g)~~ The department shall include products and services that are offered by a qualified nonprofit agency for the blind or for the other severely handicapped ~~organized pursuant to chapter 413~~ and that have been determined to be suitable for purchase pursuant to s. 413.035 on a ~~any~~ department listing of state term contracts. The products and services shall be placed on such list in a category based upon specification criteria developed by the department in consultation with the ~~qualified~~ nonprofit agency.

(e) ~~(h)~~ The department may collect fees for the use of its electronic information services. The fees may be imposed on an individual transaction basis or as a fixed subscription for a designated period of time. At a minimum, the fees shall be determined in an amount sufficient to cover the department's projected costs for ~~of~~ the services, including overhead, in accordance with the policies of the department ~~of Management Services~~ for computing its administrative assessment. All fees collected under this paragraph shall be deposited in the Operating Trust Fund for disbursement as provided by law.

(2) ~~(a)~~ To establish purchasing agreements and procure state term contracts for commodities and contractual services, pursuant to s. 287.057, under which state agencies shall, and eligible users may, make purchases pursuant to s. 287.056.

(a) The department may restrict purchases by ~~from some term contracts to~~ state agencies from ~~only for those~~ term contracts if ~~where~~ the inclusion of other governmental entities will have

an adverse effect on competition or on ~~to those~~ federal facilities located in this state. In such planning or purchasing, the office ~~of Supplier Diversity~~ may monitor to ensure that opportunities are afforded for contracting with minority business enterprises. The department, for state term contracts, and all agencies, for multiyear contractual services or term contracts, shall explore reasonable and economical means to use ~~utilize~~ certified minority business enterprises. Purchases by any county, municipality, private nonprofit community transportation coordinator designated pursuant to chapter 427~~, while~~ conducting business related solely to the Commission for the Transportation Disadvantaged, or other local public agency under the provisions in the state purchasing contracts, and purchases, from the corporation operating the correctional work programs, of products or services that are subject to paragraph (1)(c) ~~(1)(f)~~, are exempt from the competitive solicitation requirements otherwise applying to their purchases.

(b) As an alternative to ~~any provision in~~ s. 120.57(3)(c), the department may proceed with the competitive solicitation or contract award process of a term contract if ~~when~~ the secretary of the department or his or her designee sets forth in writing particular facts and circumstances that ~~which~~ demonstrate that the delay incident to staying the solicitation or contract award process would be detrimental to the interests of the state. If, after the award of the ~~a~~ contract resulting from a competitive solicitation in which a timely protest was received and in which the state did not prevail, the contract may be canceled and reawarded.

(c) Any person who files an action protesting a decision or intended decision pertaining to contracts administered by the department, a water management district, or an agency pursuant to s. 120.57(3)(b) shall post with the department, the water management district, or the agency at the time of filing the formal written protest a bond payable to the department, the water management district, or agency in an amount equal to 1 percent of the estimated contract amount. For protests of decisions or intended decisions pertaining to exceptional purchases, the bond must ~~shall be in an amount~~ equal ~~to~~ 1 percent of the estimated contract amount for the exceptional purchase.

1. The estimated contract amount shall be based upon the contract price submitted by the protestor or, if no contract price was submitted, the department, water management district, or agency shall estimate the contract amount based on factors, including, but not limited to, the price of previous or existing contracts for similar commodities or contractual services, the amount appropriated by the Legislature for the contract, or the fair market value of similar commodities or contractual services. The agency shall provide the estimated contract amount to the vendor within 72 hours, excluding Saturdays, Sundays, and state holidays, after the filing of the notice of protest by the vendor. The estimated contract amount is not subject to protest pursuant to s. 120.57(3).

2. The bond shall be conditioned upon the payment of all costs and charges that are adjudged against the protestor in the administrative hearing in which the action is brought and in any subsequent appellate court proceeding.

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3. In lieu of a bond, the department, ~~the~~ water management district, or agency may~~, in either case,~~ accept a cashier's check, official bank check, or money order in the amount of the bond.

4. If, after completion of the administrative hearing process and any appellate court proceedings, the department, water management district, or agency prevails, it shall recover all costs and charges, which must ~~shall~~ be included in the final order or judgment, excluding attorney ~~attorney's~~ fees. ~~This section shall not apply to protests filed by the Office of Supplier Diversity.~~ Upon payment of such costs and charges by the protestor, the bond, cashier's check, official bank check, or money order shall be returned to the protestor. If, after the completion of the administrative hearing process and any appellate court proceedings, the protestor prevails, the protestor may ~~shall~~ recover from the department, water management district, or agency all costs and charges that are ~~which shall be~~ included in the final order or judgment, excluding attorney ~~attorney's~~ fees.

5. This paragraph does not apply to protests filed by the office.

~~(3) To establish a system of coordinated, uniform procurement policies, procedures, and practices to be used by agencies in acquiring commodities and contractual services, which shall include, but not be limited to:~~

~~(a) Development of a list of interested vendors to be maintained by classes of commodities and contractual services. This list shall not be used to prequalify vendors or to exclude any interested vendor from bidding.~~

~~(b)1. Development of procedures for advertising solicitations. These procedures must provide for electronic posting of solicitations for at least 10 days before the date set for receipt of bids, proposals, or replies, unless the department or other agency determines in writing that a shorter period of time is necessary to avoid harming the interests of the state. The Office of Supplier Diversity may consult with the department regarding the development of solicitation distribution procedures to ensure that maximum distribution is afforded to certified minority business enterprises as defined in s. 288.703.~~

~~2. Development of procedures for electronic posting. The department shall designate a centralized website on the Internet for the department and other agencies to electronically post solicitations, decisions or intended decisions, and other matters relating to procurement.~~

~~(c) Development of procedures for the receipt and opening of bids, proposals, or replies by an agency. Such procedures shall provide the Office of Supplier Diversity an opportunity to monitor and ensure that the contract award is consistent with the requirements of s. 287.09451.~~

~~(d) Development of procedures to be used by an agency in deciding to contract, including, but not limited to, identifying and assessing in writing project needs and requirements, availability of agency employees, budgetary constraints or availability, facility equipment availability, current and projected agency workload capabilities, and the ability of any other state agency to perform the services.~~

~~(e) Development of procedures to be used by an agency in~~


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~~maintaining a contract file for each contract which shall include, but not be limited to, all pertinent information relating to the contract during the preparatory stages; a copy of the solicitation; documentation relating to the solicitation process; opening of bids, proposals, or replies; evaluation and tabulation of bids, proposals, or replies; and determination and notice of award of contract.~~

~~(f) Development of procedures to be used by an agency for issuing solicitations that include requirements to describe commodities, services, scope of work, and deliverables in a manner that promotes competition.~~

~~(g) Development of procedures to be used by an agency when issuing requests for information and requests for quotes.~~

~~(h) Development of procedures to be used by state agencies when procuring information technology commodities and contractual services that ensure compliance with public records requirements and records retention and archiving requirements.~~

~~(4)(a) To prescribe the methods of securing competitive sealed bids, proposals, and replies. Such methods may include, but are not limited to, procedures for identifying vendors; setting qualifications; conducting conferences or written question and answer periods for purposes of responding to vendor questions; evaluating bids, proposals, and replies; ranking and selecting vendors; and conducting negotiations.~~

~~(b) To prescribe procedures for procuring information technology and information technology consultant services that provide for public announcement and qualification, competitive solicitations, contract award, and prohibition against contingent fees. Such procedures are limited to information~~


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~~technology consultant contracts for which the total project costs, or planning or study activities, are estimated to exceed the threshold amount provided in s. 287.017, for CATEGORY TWO.~~

(3) ~~(5)~~ To prescribe specific commodities and quantities to be purchased locally.

~~(6)(a) To govern the purchase by any agency of any commodity or contractual service and to establish standards and specifications for any commodity.~~

(4) ~~(b)~~ Except for the purchase of insurance, to ~~the department may~~ delegate to agencies the authority for the procurement of and contracting for commodities or contractual services.

~~(7) To establish definitions and classes of commodities and contractual services. Agencies shall follow the definitions and classes of commodities and contractual services established by the department in acquiring or purchasing commodities or contractual services. The authority of the department under this section shall not be construed to impair or interfere with the determination by state agencies of their need for, or their use of, services including particular specifications.~~

~~(8) To provide any commodity and contractual service purchasing rules to the Chief Financial Officer and all agencies through an electronic medium or other means. Agencies may not approve any account or request any payment of any account for the purchase of any commodity or the procurement of any contractual service covered by a purchasing or contractual service rule except as authorized therein. The department shall furnish copies of rules adopted by the department to any county, municipality, or other local public agency requesting them.~~

(5) ~~(9)~~ To require that every agency furnish information relative to its commodity and contractual services purchases and methods of purchasing commodities and contractual services to the department when so requested.

(6) ~~(10)~~ To prepare statistical data concerning the method of procurement, terms, usage, and disposition of commodities and contractual services by agencies. All agencies shall furnish such information for this purpose to the office and to the department, as the department or office may call for, but at least ~~no less frequently than~~ annually, on such forms or in such manner as the department may prescribe.

~~(11) To establish and maintain programs for the purpose of disseminating information to government, industry, educational institutions, and the general public concerning policies, procedures, rules, and forms for the procurement of commodities and contractual services.~~

(7) ~~(12)~~ Except as otherwise provided in this section ~~herein~~, to adopt rules necessary to carry out the purposes of this section, including the authority to delegate to any agency any and all of the responsibility conferred by this section, retaining to the department any and all authority for supervision thereof. Such purchasing of commodities and procurement of contractual services by state agencies must also ~~shall~~ be in strict accordance with the rules and procedures prescribed by the Department of Financial Services.

(8) ~~(13)~~ If the department determines in writing that it is in the best interest of the state, to award to multiple suppliers contracts for commodities and contractual services established by the department for use by all agencies. Such

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awards may be on a statewide or regional basis. If regional contracts are established by the department, multiple supplier awards may be based upon multiple awards for regions. Agencies may award contracts to a responsible and responsive vendor on a statewide or regional basis.

(9) ~~(14)~~ To procure and distribute federal surplus tangible personal property allocated to the state by the Federal Government.

(10) ~~(15)~~ To enter into joint agreements with governmental agencies, as defined in s. 163.3164, for the purpose of pooling funds for the purchase of commodities or information technology that can be used by multiple agencies.

(a) Each agency that has been appropriated or has existing funds for such purchase, shall, upon contract award by the department, transfer their portion of the funds into the department’s Operating Trust Fund for payment by the department. The funds shall be transferred by the Executive Office of the Governor pursuant to the agency budget amendment request provisions in chapter 216.

(b) Agencies that sign the joint agreements are financially obligated for their portion of the agreed-upon funds. If an agency becomes more than 90 days delinquent in paying the funds, the department shall certify to the Chief Financial Officer the amount due, and the Chief Financial Officer shall transfer the amount due to the Operating Trust Fund of the department from any of the agency’s available funds. The Chief Financial Officer shall report these transfers and the reasons for the transfers to the Executive Office of the Governor and the legislative appropriations committees.

(11) ~~(16)~~ To evaluate contracts let by the Federal Government, another state, or a political subdivision for the provision of commodities and contract services, and, if it is determined in writing to be cost-effective and in the best interest of the state, to enter into a written agreement authorizing an agency to make purchases under such contract.

(12) ~~(17)(a)~~ To enter into contracts pursuant to chapter 957 for the designing, financing, acquiring, leasing, constructing, or operating of private correctional facilities. The department shall enter into such ~~a contract or~~ contracts with one contractor per facility ~~for the designing, acquiring, financing, leasing, constructing, and operating of that facility~~ or may, if specifically authorized by the Legislature, separately contract for each of ~~any~~ such services.

(a) ~~(b)~~ The department shall also ~~To~~ manage and enforce compliance with existing or future contracts entered into pursuant to chapter 957.

(b) The department may not delegate the responsibilities conferred by this subsection.

Section 7. Effective October 1, 2013, section 287.044, Florida Statutes, is created to read:

287.044 Powers, duties, and functions of the Department of Financial Services.—The Department of Financial Services is responsible for establishing and enforcing procurement and contracting policies and procedures for the Department of Management Services and all agencies. The Department of Financial Services has the following powers, duties, and functions:

(1) To establish a system of coordinated and uniform

procurement policies, procedures, and practices to be used by agencies when acquiring commodities and contractual services, which includes, but is not limited to:

(a) The development of procedures to be used by an agency for issuing or advertising solicitations which include requirements for the agency to describe commodities, services, scope of work, and deliverables in a manner that promotes competition.

1. Such procedures must provide for electronic posting of solicitations at least 10 days before the date set for receipt of bids, proposals, or replies, unless the agency determines in writing that a shorter period of time is necessary to avoid harming the interests of the state.

2. The office may consult with the department regarding the development of solicitation distribution procedures to ensure that maximum distribution is afforded to certified minority business enterprises as defined in s. 288.703.

3. The department shall designate a centralized website on the Internet for the department and other agencies to electronically post solicitations, decisions or intended decisions, and other matters relating to procurement.

(b) The development of procedures to be used by an agency when issuing requests for information and requests for quotes.

(c) The development of procedures to be used by state agencies when procuring information technology commodities and contractual services which ensure compliance with public records requirements and records retention and archiving requirements.

(d) The development of procedures for the receipt and opening of bids, proposals, or replies by an agency. Such

procedures must provide the office an opportunity to monitor and to ensure that the contract award is consistent with the requirements of s. 287.09451.

(e) The development of procedures to be used by an agency in deciding to contract, including, but not limited to, identifying and assessing in writing project needs and requirements, availability of agency employees, budgetary availability or constraints, availability of facility equipment, current and projected agency workload capabilities, and the ability of another state agency to perform the services.

(f) The development of procedures for recording and maintaining support documentation for a cost or price analysis to be performed before the award of a contract in excess of the threshold amount provided in s. 287.017 for CATEGORY FOUR. The cost or price analysis shall be used to validate the reasonableness of bids, proposals, or replies.

(g) The development of procedures to be used by state agencies when entering into contracts which ensure standard formats, quantifiable and measurable deliverables, performance measures, and financial consequences for nonperformance.

(h) The development of procedures to be used by an agency in maintaining a contract file for each contract which includes, but is not limited to, all pertinent information relating to the contract during the preparatory stages; the solicitation process, including a copy of the solicitation; the opening of bids, proposals, or replies; the evaluation and tabulation of bids, proposals, or replies; and the determination and notice of contract award.

(2) To prescribe the methods of securing competitive sealed

bids, proposals, and replies. Such methods may include, but are not limited to, procedures for identifying vendors; setting qualifications; conducting conferences or written question and answer periods for purposes of responding to vendor questions; evaluating bids, proposals, and replies; ranking and selecting vendors; and conducting negotiations.

(3) To prescribe procedures for procuring information technology and information technology consultant services which provide for public announcement and qualification, competitive solicitations, the contract award, and a prohibition against contingent fees. Such procedures are limited to information technology consultant contracts for which the total project costs, or planning or study activities, are estimated to exceed the threshold amount provided in s. 287.017 for CATEGORY TWO.

(4) To govern the purchase by an agency of any commodity or contractual service and to establish standards and specifications for a commodity. The Chief Financial Officer shall establish definitions and classes of commodities and contractual services which agencies must adhere to in acquiring or purchasing commodities or contractual services. The department's authority under this section may not impair or interfere with an agency's determination of its need for, or use of, services that include particular specifications.

(5) To provide to agencies through an electronic medium or other means rules for purchasing commodities and contractual services. Agencies may not approve any account, or request payment of any account, for the purchase of any commodity or the procurement of any contractual service covered by a purchasing or contractual service rule except as authorized by such rule.

The department shall furnish copies of rules adopted by the department to any county, municipality, or other local public agency requesting them.

(6) To establish and maintain programs that disseminate information to governmental entities, industry vendors, educational institutions, and the general public concerning policies, procedures, rules, and forms for the procurement of commodities and contractual services.

(7) To establish and maintain a list of vendors that are not allowed to do business with the state pursuant to ss. 287.132(4) and 287.133. The department may add to the list vendors that are not compliant with federal or state laws, or that the department determines have uncollected accounts that are owed to the state.

Section 8. Paragraph (f) of subsection (3) and subsections (9), (14), and (16) of section 287.057, Florida Statutes, are amended, and subsection (24) is added to that section, to read:

287.057 Procurement of commodities or contractual services.—

(3) When the purchase price of commodities or contractual services exceeds the threshold amount provided in s. 287.017 for CATEGORY TWO, no purchase of commodities or contractual services may be made without receiving competitive sealed bids, competitive sealed proposals, or competitive sealed replies unless:

(f) The following contractual services and commodities are not subject to the competitive-solicitation requirements of this section:

~~1. Artistic services. For the purposes of this subsection,~~

~~the term "artistic services" does not include advertising or typesetting. As used in this subparagraph, the term "advertising" means the making of a representation in any form in connection with a trade, business, craft, or profession in order to promote the supply of commodities or services by the person promoting the commodities or contractual services.~~

~~2. Academic program reviews if the fee for such services does not exceed $50,000.~~

~~3. Lectures by individuals.~~

1.~~4.~~ Legal services, including attorney, paralegal, expert witness, appraisal, or mediator services.

2.~~5.a.~~ Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration, and,~~.~~

~~b.~~ beginning January 1, 2011, health services, including, but not limited to, substance abuse and mental health services~~,~~ involving examination, diagnosis, treatment, prevention, or medical consultation, if ~~when~~ such services are offered to eligible individuals participating in a specific program that qualifies multiple providers and uses a standard payment methodology. Reimbursement of administrative costs for providers of services purchased in this manner are ~~shall~~ also ~~be~~ exempt. For purposes of this subparagraph ~~sub-subparagraph~~, the term "providers" means health professionals, health facilities, or organizations that deliver or arrange for the delivery of health services.

3.~~6.~~ Services provided to persons with mental or physical disabilities by not-for-profit corporations that ~~which~~ have obtained exemptions under ~~the provisions of~~ s. 501(c)(3) of the

United States Internal Revenue Code or if ~~when~~ such services are governed by the provisions of Office of Management and Budget Circular A-122. However, in acquiring such services, the agency must ~~shall~~ consider the vendor's ability ~~of the vendor~~, past performance, willingness to meet time requirements, and price.

4.~~7.~~ Medicaid services delivered to an eligible Medicaid recipient, unless the agency is directed otherwise in law.

5.~~8.~~ Family placement services.

6.~~9.~~ Prevention services related to mental health, including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways, operated by not-for-profit corporations. However, in acquiring such services, the agency must ~~shall~~ consider the vendor's ability ~~of the vendor~~, past performance, willingness to meet time requirements, and price.

~~10. Training and education services provided to injured employees pursuant to s. 440.491(6).~~

7.~~11.~~ Contracts entered into pursuant to s. 337.11.

8.~~12.~~ Services or commodities provided by governmental agencies.

(9) An agency may ~~shall~~ not divide the solicitation of commodities or contractual services so as to avoid the requirements of subsections (1)-(3) and reduce the ability of businesses to openly compete.

(14) For each contractual services contract, the agency shall designate an employee to function as contract manager who shall be responsible for enforcing performance of the contract terms and conditions and serve as a liaison with the contractor. Each contract manager who is responsible for one or more contracts in excess of the threshold amount provided under s.


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287.017 for CATEGORY FIVE ~~TWO~~ must be certified pursuant to s. 287.1312 ~~attend training conducted by the Chief Financial Officer for accountability in contracts and grant management~~. The Chief Financial Officer shall establish and disseminate uniform procedures pursuant to s. 17.03(3) to ensure that contractual services have been rendered in accordance with the contract terms before the agency processes the invoice for payment. The procedures must ~~shall~~ include, but need not be limited to, procedures for monitoring and documenting contractor performance, reviewing and documenting all deliverables for which payment is requested by vendors, and providing written certification by contract managers of the agency's receipt of goods and services.

(16) For a contract in excess of the threshold amount provided in s. 287.017 for CATEGORY FOUR, the agency head shall appoint:

(a) At least three persons to evaluate proposals and replies who collectively have experience and knowledge in the program areas and service requirements for which commodities or contractual services are sought.

(b) At least three persons to conduct negotiations during a competitive sealed reply procurement who collectively have experience and knowledge in negotiating contracts, contract procurement, and the program areas and service requirements for which commodities or contractual services are sought. When the value of a contract is in excess of $1 million in any fiscal year, at least one of the persons conducting negotiations must be certified as a contract negotiator based upon rules adopted by the Department of Financial Services ~~Management Services~~ in

order to ensure that certified contract negotiators are knowledgeable about effective negotiation strategies, capable of successfully implementing those strategies, and involved appropriately in the procurement process. At a minimum, the rules must address the qualifications required for certification, the method of certification, and the procedure for involving the certified negotiator. If the value of a contract is in excess of $10 million in any fiscal year, at least one of the persons conducting negotiations must be a Project Management Professional, as certified by the Project Management Institute.

(24) An agency or other eligible user may purchase commodities or services through another agency's existing contract rather than through competitive competition if the use of such contract is in the best interest of the state.

Section 9. Paragraph (e) of subsection (1) of section 287.058, Florida Statutes, is amended, and subsections (7) through (11) are added to that section, to read:

287.058 Contract document.—

(1) Every procurement of contractual services in excess of the threshold amount provided in s. 287.017 for CATEGORY TWO, except for the providing of health and mental health services or drugs in the examination, diagnosis, or treatment of sick or injured state employees or the providing of other benefits as required by the provisions of chapter 440, shall be evidenced by a written agreement embodying all provisions and conditions of the procurement of such services, which shall, where applicable, include, but not be limited to, a provision:

(e) Dividing the contract into quantifiable, measurable,

and verifiable units of deliverables which ~~that~~ must be received and accepted in writing by the contract manager before payment. Each deliverable must be directly related to the scope of work and specify a performance measure. As used in this paragraph, the term "performance measure" means the required minimum level of service to be performed and criteria for evaluating the successful completion of each deliverable.

In lieu of a written agreement, the department may authorize the use of a purchase order for classes of contractual services, if the provisions of paragraphs (a)-(i) are included in the purchase order or solicitation. The purchase order must include, but need not be limited to, an adequate description of the services, the contract period, and the method of payment. In lieu of printing the provisions of paragraphs (a)-(i) in the contract document or purchase order, agencies may incorporate the requirements of paragraphs (a)-(i) by reference.

(7) The Chief Financial Officer may review and approve contracts subject to this chapter before the execution of such contracts in accordance with rules adopted by the department. The review must ensure that all contracting laws have been met; that the contract document contains a clear statement of work, quantifiable and measureable deliverables, performance measures, financial consequences for nonperformance, and clear terms and conditions that protect the interests of the state; that documentation is available to support the contract; and that the associated costs of the contract are not unreasonable or inappropriate. A contract that does not comply with this subsection may be rejected and returned to the submitting agency

for revision.

(8) The Chief Financial Officer may establish dollar thresholds and other criteria for sampling the agreements that are to be reviewed prior to execution. The Chief Financial Officer may revise such thresholds and other criteria for an agency or the unit of any agency as he or she deems appropriate.

(9) The department's review of contract documentation may include, but need not be limited to:

(a) Evidence of advertising the procurement opportunity, if applicable;

(b) The bid, proposal, or reply itself, whether an invitation to bid, request for proposals, or invitation to negotiate, as applicable;

(c) The preprocurement conference questions and answers;

(d) Any additional documentation provided to bidders, proposers, or repliers;

(e) The list of bidders, proposers, or repliers solicited;

(f) The evaluation instrument and process description related to the contract;

(g) The bid tabulation or evaluation record;

(h) Documentation that supports the agency's determination of vendor responsibility;

(i) The successful bid, proposal, or reply in addition to the unsuccessful bids, proposals, or replies;

(j) Documentation that supports the selection of the contractor;

(k) The reasonableness of the price;

(l) Verification that all statutory and regulatory requirements have been met; and

(m) The proposed contract.

(10) The department shall verify that a competitive process was used, if required by law, and that the contract was appropriately awarded on the basis of lowest price or best value to a responsive and reasonable bidder, proposer, or replier. For contracts not competitively awarded, the procurement record shall be reviewed for restrictive specifications and the agency's justification for the noncompetitive method used in awarding the contract, including justification for the selection of the vendor and the reasonableness of the terms.

(11) The department has 30 days to make a final determination regarding approval of a contract. The department and the agency entering into the contract may agree to a longer review period to ensure the thorough consideration of the procurement process and its results.

Section 10. Section 287.1312, Florida Statutes, is created to read:

287.1312 Contract manager certification.—

(1) The Department of Financial Services shall establish a training certification program for contract and grant managers and negotiators of contracts and grants. A state employee may not manage a contract or grant agreement in excess of the threshold amount provided in s. 287.017 for CATEGORY FIVE without obtaining a valid certification from the Department of Financial Services under this section. The program must include training in the following areas:

(a) Procurement and the development of contracts.

(b) Development and administration of grant agreements involving federal and state financial assistance.


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(c) Responsibilities of a contract manager in the management of state contracts and grant agreements.

(d) Federal and state audit and reporting requirements.

(e) Laws and rules relating to procurement and contract administration.

(f) Any other subject matter that the Chief Financial Officer determines will promote accountability in contract and grant management.

(2) The program shall provide for periodic recertification, as necessary. The Department of Financial Services shall determine course requirements, maintain information on certifications, and monitor the performance of contract and grant managers. As part of such monitoring, the department shall annually publish the results of agency manager audits and error rates related to contract and grant management on its website.

(3) The Department of Financial Services may revoke a manager's certification for incompetence or conduct inconsistent with the responsibilities of contract or grant management.

(4) The Department of Financial Services shall adopt rules to administer this section.

Section 11. Paragraph (d) of subsection (1) of section 287.133, Florida Statutes, is amended to read:

287.133 Public entity crime; denial or revocation of the right to transact business with public entities.—

(1) As used in this section:

(d) "Department" means the Department of Financial ~~Management~~ Services.

Section 12. Paragraph (h) of subsection (3) of section 255.25, Florida Statutes, is amended to read:


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255.25 Approval required prior to construction or lease of buildings.—

(3)

(h) ~~The Department of Management Services may,~~ Pursuant to s. 287.042(2)~~(a)~~, the department shall procure a term contract for real estate consulting and brokerage services. A state agency may not purchase services from the contract unless the contract has been procured under s. 287.057(1) after March 1, 2007, and contains the following provisions or requirements:

1. Awarded brokers ~~must~~ maintain an office or presence in the market served. In awarding the contract, preference must be given to brokers who ~~that~~ are licensed in this state under chapter 475 and who ~~that~~ have 3 or more years of experience in the market served. The contract may be made with up to three tenant brokers in order to serve the marketplace in the north, central, and south areas of the state.

2. Each contracted tenant broker works ~~shall work~~ under the direction, supervision, and authority of the state agency, subject to the rules governing lease procurements.

3. The department provides ~~shall provide~~ training for the awarded tenant brokers concerning the rules governing the procurement of leases.

4. Tenant brokers ~~must~~ comply with all applicable provisions of s. 475.278.

5. Real estate consultants and tenant brokers are ~~shall be~~ compensated by the state agency, subject to the provisions of the term contract, and such compensation is subject to appropriation by the Legislature. A real estate consultant or tenant broker may not receive compensation directly from a

lessor for services that are rendered under the term contract. Moneys paid by a lessor to the state agency under a facility leasing arrangement are not subject to the charges imposed under s. 215.20. All terms relating to the compensation of the real estate consultant or tenant broker must ~~shall~~ be specified in the term contract and may not be supplemented or modified by the state agency using the contract.

6. The department conducts ~~shall conduct~~ periodic customer-satisfaction surveys.

7. Each state agency reports ~~shall report~~ the following information to the department:

a. The number of leases that adhere to the goal of the workspace-management initiative of 180 square feet per full-time employee ~~FTE~~.

b. The quality of space leased and the adequacy of tenant-improvement funds.

c. The timeliness of lease procurement, measured from the date of the agency's request to the finalization of the lease.

d. Whether cost-benefit analyses were performed before execution of the lease in order to ensure that the lease is in the best interest of the state.

e. The lease costs compared to market rates for similar types and classifications of space according to the official classifications of the Building Owners and Managers Association.

Section 13. Subsection (12) of section 287.012, Florida Statutes, is amended to read:

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

(12) "Exceptional purchase" means any purchase of commodities or contractual services excepted by law or rule from


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the requirements for competitive solicitation, including, but not limited to, purchases from a single source; purchases upon receipt of fewer ~~less~~ than two responsive bids, proposals, or replies; purchases made by an agency, after receiving approval from the department, from a contract procured, pursuant to s. 287.057(1), or by another agency; and purchases made without advertisement in the manner required under ~~by~~ s. 287.044(1)(a) ~~287.042(3)(b)~~.

Section 14. Paragraph (a) of subsection (2) of section 402.7305, Florida Statutes, is amended to read:

402.7305 Department of Children and Family Services; procurement of contractual services; contract management.—

(2) PROCUREMENT OF COMMODITIES AND CONTRACTUAL SERVICES.—

(a) Notwithstanding s. 287.057(3)(f)8. ~~287.057(3)(f)12.~~, if ~~whenever~~ the department intends to contract with a public postsecondary institution to provide a service, the department must allow all public postsecondary institutions in this state which ~~that~~ are accredited by the Southern Association of Colleges and Schools to bid on the contract. Thereafter, notwithstanding any other provision of law ~~to the contrary~~, if a public postsecondary institution intends to subcontract for any service awarded in the contract, the subcontracted service must be procured by competitive procedures.

Section 15. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the policies and procedures of the commission, shall:

(3) Not procure transportation disadvantaged services


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without initially negotiating with the commission, as provided in s. 287.057(3)(f)8. ~~287.057(3)(f)12.~~, or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) and as otherwise limited or directed by the General Appropriations Act.

Section 16. Subsection (2) of section 946.515, Florida Statutes, is amended to read:

946.515 Use of goods and services produced in correctional work programs.—

(2) A ~~No~~ similar product or service of comparable price and quality found necessary for use by any state agency may not be purchased from any source other than the corporation if the corporation certifies that the product is manufactured by, or the service is provided by, inmates and the product or service meets the comparable performance specifications and comparable price and quality requirements as specified under s. 287.042(1)(c) ~~287.042(1)(f)~~ or as determined by an individual agency as provided in this section. The purchasing authority of ~~any~~ such state agency may make reasonable determinations of need, price, and quality with reference to products or services available from the corporation. In the event of a dispute between the corporation and a ~~any~~ purchasing authority based upon price or quality under this section or s. 287.042(1)(c)


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~~287.042(1)(f)~~, either party may request a hearing with the Department of Management Services and, if not resolved, ~~either party~~ may request a proceeding pursuant to ss. 120.569 and 120.57, which shall be referred to the Division of Administrative Hearings within 60 days after such request, to resolve any dispute under this section. A ~~No~~ party is not entitled to any appeal pursuant to s. 120.68.

Section 17. Procurement review and report.—

(1) The Chief Financial Officer shall review and investigate:

(a) All current state laws that govern the state procurement of goods, services, and facilities;

(b) The procurement policies, rules, procedures, and practices followed by the state agencies, boards, commissions, offices, and other instrumentalities of the executive branch of state government;

(c) The organization and management processes involved in the state procurement of goods, services, and facilities before the award of a state procurement contract, during the solicitation of bids, the evaluation, and the negotiation of a contract, and subsequent to the award of the contract to determine the extent to which these organization and management processes facilitate the legislative policy set forth in this act; and

(d) Any other areas that the Chief Financial Officer deems relevant to the review and investigation.

(2) In order to accomplish the procurement review directed by this section, the Chief Financial Officer may:

(a) Acquire information directly from the head of any state

department or agency for the purpose of conducting this review. All departments and agencies shall cooperate with the Chief Financial Officer and furnish all information requested to the extent permitted by law.

(b) Procure the services of experts and consultants.

(c) Contract with private organizations and nonprofit institutions to carry out studies and prepare reports to facilitate the review.

(3) By December 31, 2012, the Chief Financial Officer shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of findings and recommendations for changes in statutes, rules, policies, procedures, and organization necessary to carry out the policies set forth in this act.

Section 18. The Legislature recognizes the need to reform the purchasing cycle, from the development of a purchasing agreement to the payment for goods or services provided to the state. Therefore, chapter 287, Florida Statutes, is repealed effective July 30, 2014.

Section 19. (1) For the 2012-2013 fiscal year, the sum of $400,000 in nonrecurring funds is appropriated from the Administrative Trust Fund in the Department of Financial Services to contract for the Chief Financial Officer’s review of the state’s procurement process.

(2) For the 2012-2013 fiscal year, the sum of $375,000 in nonrecurring funds is appropriated from the Administrative Trust Fund in the Department of Financial Services to contract for the Chief Financial Officer’s administration of the certified contract manager and negotiator programs.

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(3) For the 2012-2013 fiscal year, the sum of $X00,000 in recurring funds from the General Revenue fund and full-time equivalent positions and associated salary rate of are appropriated to the Chief Financial Officer for the purpose of implementing the Chief Financial Officer's expanded contract auditing responsibilities under this act. Funds remaining unexpended or unencumbered from this appropriation as of June 30, 2013, shall revert and be reappropriated for the same purpose in the 2013-2014 fiscal year.

Section 20. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2012.

================ 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 state contracting; amending s. 11.45, F.S.; conforming provisions to changes made by the act; amending s. 215.971, F.S.; requiring agreements funded with state or federal financial assistance to include a performance measure for each deliverable, to be reviewed and approved in accordance with rules adopted by the Department of Financial Services, and to have the contracting entity assign a grants manager who is responsible for enforcing performance of the agreement; amending s. 215.985, F.S.; revising provisions relating to the Chief Financial Officer's intergovernmental contract

tracking system under the Transparency Florida Act; specifying the entities that are included in the tracking system; requiring that exempt and confidential information be redacted from contracts and procurement documents posted on the system; authorizing the Chief Financial Officer to make available the information posted on the system to the public through a secure website; authorizing the Department of Financial Services to adopt rules; repealing s. 216.0111, F.S., relating to a requirement that state agencies report certain contract information to the Department of Financial Services and transferring that requirement to s. 215.985, F.S.; amending s. 287.032, F.S.; dividing the responsibilities of the Department of Management Services under ch. 287, F.S., with the Department of Financial Services; amending s. 287.042, F.S.; limiting the duties of the Department of Management Services to the procurement of commodities and contractual services; directing the department to develop a list of interested vendors; deleting provisions requiring that the department perform duties relating to procurement and contracting policies and procedures; creating s. 287.044, F.S.; assigning duties relating to procurement and contracting policies and procedures to the Department of Financial Services; requiring the department to develop a list of vendors not allowed to do business with the state; amending s. 287.057, F.S.; revising

the list of contractual services and commodities that are exempt from competitive solicitation to delete certain services from the exemption; revising provisions prohibiting an agency from dividing a solicitation; conforming provisions to changes made by the act; authorizing an agency or other eligible user to purchase commodities or services through another agency's contract; amending s. 287.058, F.S.; requiring contracts to include a performance measure for each deliverable; authorizing the Chief Financial Officer to review and approve contracts; providing requirements for such reviews; authorizing the Chief Financial Officer to establish dollar thresholds and another criteria for sampling agreements that are to be reviewed before execution; providing criteria for the department's review of contract documentation; requiring that the department verify that a competitive process was used and that a contract was appropriately awarded; providing for the review of procurement record for contracts not competitively awarded; specifying the number of days that the department must make its final determination regarding the approval of a contract; authorizing the department and the agency to agree to a longer review period; creating s. 287.1312, F.S.; requiring certification of contract managers by the Department of Financial Services for contracts of more than a certain amount; requiring the training program for the certification to provide training in certain areas; authorizing the

department to adopt rules to administer the program; amending s. 287.133, F.S.; revising the definition of "department" to mean the Department of Financial Services rather than the Department of Management Services with respect to provisions governing public entity crimes and placement on the convicted vendor list; amending ss. 255.25, 287.012, 402.7305, 427.0135, and 946.515, F.S.; conforming cross-references; requiring the Chief Financial Officer to conduct a study of current procurement laws pursuant to such policies; requiring that the Chief Financial Officer submit a report to the Legislature and Governor by a certain date on such study; repealing ch. 287, F.S., on a future date; providing appropriations; providing effective dates.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/02/2012	.	
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	.	
	.	

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

Senate Amendment to Amendment (725782) (with title amendment)

Between lines 897 and 898
insert:
Section 10. Subsection (3) of section 287.095, Florida Statutes, is repealed.

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Delete line 1196
and insert:

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and the agency to agree to a longer review period; repealing s. 287.095(3), F.S., relating to certain products produced by inmate labor;

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/12
Meeting Date

Topic _____ Bill Number 1626 *(if applicable)*

Name Kraig Conn Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 301 S. Bronough Phone 222 9684
Street

Tall FL 32301 E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida League of Cities

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-2-12
Meeting Date

Topic _____ Bill Number 1626 *(if applicable)*

Name Tarren Bragdon Amendment Barcode _____ *(if applicable)*

Job Title CEO

Address 15275 Collier Blvd, Ste 201-279 Phone 239.244.8839
Street

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Speaking: ☒ For ☐ Against ☐ Information

Representing Foundation for Government Accountability

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2.2.12
Meeting Date

Topic Contracting

Bill Number 1426 *(if applicable)*

Name Ashley Hayes

Amendment Barcode _____ *(if applicable)*

Job Title Dir. Policy & Legislative Affairs

Address Capitol - PL-11
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Speaking: [X] For [ ] Against [ ] Information

Representing CFO Atwater

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

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 1626
INTRODUCER:	Banking and Insurance Committee and Senator Gaetz
SUBJECT:	State Contracting
DATE:	February 2, 2012
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rubio	Burgess	BI	**Fav/CS**
2.			GO	
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 Department of Management Services (DMS) is responsible for promoting efficiency and to effect coordination in the purchase of commodities and contractual services for the state, providing uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users, and procuring and distributing federal surplus tangible personal property allocated to the state by the Federal Government.

The Chief Financial Officer (CFO) is the chief fiscal officer of the state and through the Department of Financial Services (DFS) examines, audits, and settles all accounts, claims, and demands against the state, arising under any law or resolution of the Legislature, and for issuing a warrant directing the payment out of the State Treasury of such amount.

The Office of the Auditor General (AG) conducts financial audits of the accounts and records of State agencies, conducts operational and performance audits of public records and information technology systems, adopts rules for financial audits performed by independent certified public accountants of local governmental entities, and reviews all audit reports of local governmental entities.

Under the bill the duties of the Department of Management Services (DMS) are limited to the procurement of commodities and contractual services, collecting data, and preparing statistical reports on the agencies' use of methods of procurement. The responsibility and authority to develop procurement related rules, policy, and practice will be transferred to the Department of Financial Services (DFS). Provisions relating to the Chief Financial Officer's (CFO) intergovernmental contract tracking system under the Transparency Florida Act are revised by the bill. The bill also requires the CFO to conduct a study of current procurement laws to be submitted to the Legislature and Governor.

This bill substantially amends the following sections of the Florida Statutes: 11.45, 215.971, 215.985, 255.25, 287.012, 287.032, 287.042, 287.057, 287.058, 287.095, 287.133, 402.7305, 427.0135, and 946.515.

This bill repeals the following sections of the Florida Statutes: 216.0111, and ch. 287 (effective July 30, 2014).

This bill creates the following sections of the Florida Statutes: 287.044, and 287.1312.

II. Present Situation:

Department of Management Services and Chapter 287, F.S.

Under ch. 287, F.S., the Division of State Purchasing in the Department of Management Services (DMS) is responsible for developing and administering standardized procurement policies, procedures, and practices to be used by state agencies in acquiring commodities, contractual services, and information technology. A variety of procurement methods are available for use by the agencies depending on the cost and characteristics of the needed good or service, the complexity of the procurement, and the number of available vendors. To guide the procedures for the procurement method to be used, the type of review required, and the method for the award of any contract the following purchasing categories with threshold amounts have been established:

- Category one: $20,000
- Category two: $35,000
- Category three: $65,000
- Category four: $195,000
- Category five: $325,000[1]

The DMS prescribes methods of securing competitive sealed bids, proposals, and replies.[2] The competitive solicitation process must be used for procurement of commodities or contractual services in excess of the category two threshold amount, and include the following solicitation methods: invitations to bid, requests of proposals, and invitations to negotiate.[3] Many services procured by state agencies are exempt from competitive solicitation requirements regardless of

[1] Section 287.017, F.S.
[2] Rule 60A-1.041, F.A.C.
[3] Section 287.057, F.S.

whether the purchase exceeds the applicable cost threshold, including artistic services, auditing services, and legal services.[4] Agencies currently must seek approval from the DMS to use an alternate contract source to purchase commodities or services from term contracts or requirements contracts competitively established by other governmental entities. In approving the alternate contract source, the DMS determines that the contract source is cost-effective and in the best interest of the State.[5]

All agreements in excess of the category two threshold must be evidenced by a written agreement and include provisions for the required minimum level of service to be performed by the contractor, criteria for evaluating the successful completion of each deliverable, and financial consequences for nonperformance. There must also be a provision dividing the contract into quantifiable, measurable, and verifiable units of deliverables that must be received and accepted in writing by the contract manager before payment. Each deliverable must be directly related to the scope of work and specify the required minimum level of service to be performed and criteria for evaluating the successful completion of each deliverable.[6]

Each agency is required to appoint at least one contract administrator responsible for maintaining a contract file and financial information on all contractual services contracts and who serves as a liaison with the contract managers and the DMS.[7] The DMS designates certain minimum required documentation that must be in the contract file. Additionally, for each contractual services contract the agency must designate an employee to function as contract manager who shall be responsible for enforcing performance of the contract terms and conditions and serve as a liaison with the contractor, but there is no similar requirement for grants. Each contract manager who is responsible for contracts in excess of the threshold amount for category two ($35,000) must attend training conducted by the CFO for accountability in contracts and grant management.[8] Additional certifications were later required for contracts in excess of category four threshold[9] and $250,000 annual funding was appropriated to accomplish the certification, however no funding has been appropriated for this purpose for the past fiscal year.[10] The DMS currently offers several training and certification programs including an optional Florida Certified Contract Manager designation.

Under s. 287.057(18), F.S., agencies must establish a review and approval process to be completed before contracts exceeding category three threshold ($65,000) are executed. Under s. 216.3475, F.S., each agency shall maintain records to support a cost analysis, which includes a detailed budget submitted by the person or entity awarded funding and the agency's documented review of individual cost elements from the submitted budget for allowability, reasonableness, and necessity.

Using these various procurement methods the DMS also negotiates state term contracts and purchasing agreements that are intended to leverage the states' buying power. The DMS is also

[4] Section 287.057(3)(f), F.S.
[5] Rule 60A-1.047, F.A.C.
[6] Section 287.058(1), F.S.
[7] Section 287.057(15), F.S.
[8] Section 287.057(14), F.S.
[9] Section 287.057(16)(b), F.S.
[10] Department of Management Services SB1626 Bill Analysis, January 23, 2012.

responsible for compiling statistical procurement data concerning the method of procurement, terms, usage, and disposition of commodities and contractual services by agencies.[11] This data is available in the Florida Accounting Information Resource Subsystem (FLAIR) and the State's My Florida Market Place (MFMP) centralized e-procurement system.[12]

The DMS facilitates the production and processing of these competitive solicitations through the MFMP system, which is the state's e-procurement system, and provides a standardized process for developing and processing solicitations. The MFMP system has four modules: the Buyer Module, Invoicing Module, Vendor Registration Module, and Sourcing Module. However, according to the DMS, the individual state agencies determine whether to use the MFMP e-procurement system.[13] The DMS develops procedures to be used by agencies for advertising and issuing solicitations through the Vendor Bid System. Currently all solicitations and procurement related decisions/intended decisions are required to be posted on the Vendor Bid System.[14] The DMS currently posts lists of firms not permitted to do business with the state online.[15] The DMS also maintains a list of vendors by classes of commodities within the MFMP system.[16]

In August 2011, the DMS with the participation of eight agencies and nine local government representatives initiated the Procurement Process Improvement Project to examine the policy, procedure, practice, and technology for conducting procurements. The intent of the project is to improve the effectiveness and efficiency of state purchasing through establishing standardized processes and procedures, better leveraging the MFMP sourcing module, and developing a continuous improvement protocol to better monitor and actively manage sourcing activities.[17]

Chief Fiscal Officer

The CFO is the chief fiscal officer of the state and is responsible for examining, auditing, settling, and approving payment of all accounts against the state and keeping all state funds and securities.[18] The CFO functions are carried out by the Department of Financial Services (DFS). The DFS's Division of Accounting and Auditing pays all the state's bills, including employees' salaries, payments for goods and a service used by state agencies and benefit payments, promotes financial accountability throughout state government by providing information about its fiscal soundness, and investigates allegations of waste, fraud and abuse of taxpayers' money.[19]

[11] Section 287.042(10), F.S.
[12] Department of Management Services Operational Audit, Report No. 2011-075, January 2011.
[13] Department of Management Services SB 1626 Bill Analysis, January 23, 2012.
[14] http://myflorida.com/apps/vbs/vbs_www.main_menu
[15] http://www.dms.myflorida.com/business_operations/state_purchasing/vendor_information/convicted_suspended_discriminatory_complaints_vendor_lists
[16] Department of Management Services SB1626 Bill Analysis, January 23, 2012.
[17] Department of Management Services Bill Analysis, January 23, 2012.
[18] Section 17.001, F.S.
[19] Department of Financial Services website, http://www.myfloridacfo.com/sitePages/agency/sections/AccountingAuditing.aspx, (last viewed January 31, 2012).

Transparency Florida Act

Section 215.985, F.S., (Transparency Florida Act) authorized the establishment of a public access website to financial information of governmental entities, including state, regional, county, municipal, special district, or other political subdivisions whether executive, judicial, or legislative, any department, division, bureau, commission, authority, district, or agency thereof, or any public school, Florida College System institution, state university, or associated board.[20] The initial phase included appropriations data and expenditure data for all branches of state government. Under the Act, the CFO must provide public access to a state contract management system that provides information and documentation relating to contracts procured by governmental entities.[21] The data collected in the system must include the specified information including the name of the contracting agency, the procurement method, the contract dates, and the type of commodity or service. Within 30 days after a major change to an existing contract, the affected state governmental entity or agency must update the necessary information in the system. A major change to a contract includes, but is not limited to, a renewal, termination, or extension of the contract or an amendment to the contract.

Office of the Auditor General

The Office of the Auditor General (AG) conducts financial audits of the accounts and records of State agencies, conducts operational and performance audits of public records and information technology systems, adopts rules for financial audits performed by independent certified public accountants of local governmental entities, and reviews all audit reports of local governmental entities.[22] The AG must annually notify the President of the Senate, the Speaker of the House of Representatives, and the Department of Financial Services of all educational entities and water management districts that have failed to comply with transparency requirements as identified in audit reports.[23]

Prison Rehabilitative Industries and Diversified Enterprise, Inc (Pride)

In 1981 the Prison Rehabilitative Industries and Diversified Enterprises, Inc. (Pride) was created as a 501(c) 3, non-profit corporation. Pride effectively transferred the administrative and operational control of Florida's prison industries from the Florida Department of Corrections to Pride. One of the missions of Pride is to provide a joint effort between the department, the correctional work programs, and other vocational training programs to reinforce relevant education, training, and post-release job placement and help reduce recommitment of inmates.[24] Under s. 287.095, F.S., all products offered for purchase to a state agency by Pride must be produced in majority part by inmate labor, except for products not made by inmates which products are contractually allied to products made by inmates which are offered by the corporation, provided the value of the products not made by inmates do not exceed 2 percent of the total sales of the corporation in any year.

[20] Section 215.985(2)(a), F.S.
[21] Section 215.985(16), F.S.
[22] Section 11.45(2), F.S.
[23] Section 11.45(7)(i), F.S.
[24] Section 946.501(2), F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 11.45(7)(a) and (7)(i), F.S., to require the AG to provide notification of certain governmental entities' failure to comply with the requirements of s. 215.985, F.S., (Transparency Florida Act), in addition to s. 218.39, F.S., (annual financial audit reports).

Section 2 amends s. 215.971, F.S., to require an agency agreement funded with federal or state financial assistance to specify a "performance measure," defined as the required minimum level of service to be performed and the criteria for evaluating the successful completion of each deliverable. Effective October 1, 2012, before execution the agreements are required to undergo review and approval, in accordance with rules adopted by the DFS, to ensure the agreement contains a clear statement of work, quantifiable deliverables, performance measures, and financial consequences for nonperformance. Under the bill the CFO may establish dollar thresholds and criteria for sampling the agreements that are to be reviewed prior to execution. The DFS has 30 days to make a final determination regarding approval of the agreement; this review period may be extended to ensure a thorough review. The contracting agency is also required to designate an employee as the grant manager responsible for enforcing performance of the agreement terms and serve as a liaison with the recipient. The bill also requires certification of grant managers responsible for agreements in excess of category five ($325,000) and authorizes the CFO to establish uniform procedures for payment requests. According to the DMS, since s. 287.057(18), F.S., requires agencies to establish a review and approval process for contracts exceeding category three ($65,000), this external review requirement would slow the contracting process and create an administrative burden on existing contracting resources.[25]

Section 3 amends s. 215.985(16), F.S., (Transparency Florida Act) to require the CFO to establish and maintain a secure, shared, intergovernmental contract tracking system. The bill requires certain state entities and effective November 1, 2013, local governmental entities, independent special districts, district school boards, board of governors of the state university system, and the board of trustees for each Florida college system to post within 30 calendar days after executing a contract certain specified information and documentation, with any exempt or confidential information properly redacted, on the contract tracking system. Within 30 calendar days of a major modification or amendment to an existing contract, as determined by the CFO, the agency must update the information in the system. The bill provides for a party to a contract to request exempt or confidential information on the system to be redacted through a written request submitted by approved means. The bill provides a disclaimer from liability for the failure to redact information properly for the CFO and the DFS. The bill allows the CFO to make information posted on the system available for viewing and downloading by the public. The CFO may prohibit the posting of records on the public website that could jeopardize the health, safety, or welfare of the public. Additionally the bill requires certain disclosures to be conspicuously displayed on the website. The bill provides the DFS authority to adopt rules to administer the subsection. According to the DMS the MFMP system will be required to be adapted to assist in the collection of data necessary.[26]

[25] Department of Management Services SB 1626 Bill Analysis, January 23, 2012.
[26] Department of Management Services SB 1626 Bill Analysis, January 23, 2012.

Section 4 repeals s. 216.0111, F.S., and transfers the list of certain information agencies are required to provide to the DFS regarding the agencies' contracted activities to s. 215.985, F.S.

Section 5 amends s. 287.032, F.S., to limit the responsibility of the DMS, effective October 1, 2013, to coordinating the purchase of commodities and contractual services for the state and procuring and distributing federal surplus tangible personal property allocated to the state by the federal government. The bill transfers the responsibility of providing uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users to the DFS. The DFS is also required to monitor agencies compliance.

Section 6 amends s. 287.042, F.S., effective October 1, 2013, to list the revised power, duties, and functions of the DMS in procuring commodities and contractual services for agencies. The bill revises certain references from the DMS to the DFS. Under the bill, the DMS is not responsible for the establishment of policies or procedures for procurement and contracting, therefore provisions relating to these are deleted from s. 287.042, F.S. The bill requires the DMS to develop and maintain a list of interested vendors, of which vendors barred by the CFO may not be included. Under the bill the DMS continues to be responsible for preparing statistical data concerning the method of procurement, terms, usage, and disposition of commodities and contractual services by agencies. The DMS indicates that it is currently engaged in a pilot program to revise its spend analytics function used to enhance the agencies' ability to identify needs and assess the market for their product or service and its procurement process improvement project is in the process of developing new initiatives that will be piloted for state purchasing contracts. However, these will would be delayed or cancelled as a result of the transition of responsibilities.[27]

Section 7 creates s. 287.044, F.S., effective October 1, 2013, and transfers the powers, duties, and functions associated with establishing a system of coordinated and uniform procurement policies, procedures, and practices to be used by agencies when acquiring commodities and contractual services from the DMS to the DFS. The bill requires the DFS to develop numerous procurement procedures to be used by an agency including procedures for advertising solicitations, issuing requests for information and quotes, procuring information technology commodities or contractual services, entering contracts to ensure standard formats and measurable deliverables, and maintaining a contract file. The bill removes the requirement that state agencies provide an explanation to unsuccessful bidders and the requirement that DFS develop a methodology to calculate cost savings achieved under a contract. The bill requires the DFS to establish a list of vendors that are not allowed to do business with the state.

Section 8 amends and creates certain subsections to s. 287.057, F.S. The bill changes reference to the DMS in s. 287.057(16), F.S., to the DFS; therefore requiring the DFS to adopt rules for certifying contract negotiators. The bill deletes the exemptions from competitive solicitation requirements for artistic services, academic program reviews, lectures by individuals, and training and education services provided to injured employees. The bill removes the language requiring state agencies consider all purchases of the same commodity or service during one year to be part of a single purchase. The bill adds a provision to the section that allows agencies to

[27] Department of Management Services SB 1626 Bill Analysis, January 23, 2012.

purchase commodities or services through another agency's existing contract if in the best interest of the state.

Section 9 amends s. 287.058, F.S., by defining the minimum level of service to be performed and criteria for evaluating the successful completion of each deliverable specified in a contract as a performance measure. The bill provides that the CFO may review and approve contracts prior to execution in accordance with rules adopted by the DFS. The CFO may establish dollar thresholds and criteria for sampling the agreements that are to be reviewed prior to execution. The bill also provides a list of documentation the DFS may search for when reviewing contracts. The DFS has 30 days to make a final determination regarding approval of a contract, which may be extended to ensure a thorough review.

Section 10 repeals s. 287.095(3), F.S., which required the products offered for purchase to a state agency by the non-profit corporation organized to lease and manage the correctional work programs under ch. 946, F.S., be produced in majority part by inmate labor.

Section 11 creates s. 287.1312, F.S., requiring the DFS to establish a certification program for managers and negotiators of contracts and grants. In order to manage an agreement in excess of the category five threshold ($325,000), contract and grant managers must hold a valid certification from the DFS. The bill lists the areas of training that must be included in the certification program. The bill requires the DFS to monitor the program and annually publish results of agency manager audits and error rates related to contract and grant management on its website.

Sections 12 -17 provide technical, conforming changes.

Section 18 requires the CFO to review and investigate current procurement and submit the report findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2012.

Section 19 provides for the repeal of ch. 287, F.S., effective July 30, 2014.

Section 20 provides an appropriation to implement the provisions of the bill. See Government Sector Impact.

Section 21 provides an effective date of July 1, 2012, except as otherwise expressly provided.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18, Florida Constitution:

"No county or municipality shall be bound by any general law requiring such county or municipality to spend funds or to take an action requiring the expenditure of funds

unless the legislature has determined that such law fulfills an important state interest…"

If the Florida Transparency Act posting requirement for local governmental entities under the bill will result in additional expenditures for the local entities then one of the additional requirements under Article VII, s. 18, Florida Constitution, must be met.

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:

It is indeterminate whether the transfer of duties from DMS to DFS will impact potential vendors with the state.

C. Government Sector Impact:

The bill provides for an appropriation during the 2012-13 fiscal year of $400,000 in nonrecurring funds from the Administrative Trust Fund in the DFS for the CFO's review of the state's procurement process. The bill also provides for $375,000 in nonrecurring funds from the Administrative Trust Fund in the DFS to contract for the CFO's administration of the certified contract manager and negotiator program. For the 2012-13 fiscal year an indeterminate amount of recurring funds from the General Revenue fund and an indeterminate number of full-time positions are appropriated to the CFO for the purpose of implementing the CFO's expanded contract auditing responsibilities. At the end of the 2013-14 fiscal year any remaining funds shall revert and be re-appropriated for the same purpose.

VI. Technical Deficiencies:

None.

VII. Related Issues:

With the transition of the responsibility to establish and enforce procurement policies, procedures, and practices to be used by agencies when acquiring commodities and contractual services to the DFS; it is unclear whether the DMS would lose the transaction fees assessed for use of the MFMP system.

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 Banking and Insurance on February 2, 2012:

The bill retains many of the same provisions of the bill as filed and makes the following major changes:

- Provides for the establishment, by the CFO, of dollar thresholds and criteria for determining agreements funded with state or federal assistance that are to be reviewed prior to execution.
- Provides that the CFO may review and approve contracts prior to execution in accordance with rules adopted by the DFS.
- Allots 30 days for the DFS to make a final determination regarding approval of the agreement; which may be extended to ensure a thorough review.
- Provides a list of records the DFS may search for when reviewing contracts.
- Requires the DFS to establish a training certification program for negotiators of contracts and grants.
- Inserts and revises effective dates for certain provisions.
- Makes drafting changes to the bill by inserting and revising sections and deleting certain language.

B. Amendments:

None.

By Senator Gaetz

4-00922C-12 20121626__

A bill to be entitled

An act relating to state contracting; amending s. 11.45, F.S.; conforming provisions to changes made by the act; amending s. 215.971, F.S.; requiring agreements funded with state or federal financial assistance to include a performance measure for each deliverable, to be reviewed and approved in accordance with rules adopted by the Department of Financial Services, and to have the contracting entity assign a grants manager who is responsible for enforcing performance of the agreement; amending s. 215.985, F.S.; revising provisions relating to the Chief Financial Officer's intergovernmental contract tracking system under the Transparency Florida Act; specifying the entities that are included in the tracking system; requiring that exempt and confidential information be redacted from contracts and procurement documents posted on the system; authorizing the Chief Financial Officer to make available the information posted on the system to the public through a secure website; repealing s. 216.0111, F.S., relating to a requirement that state agencies report certain contract information to the Department of Financial Services and transferring that requirement to s. 215.985, F.S.; amending s. 287.032, F.S.; dividing the responsibilities of the Department of Management Services under ch. 287, F.S., with the Department of Financial Services; amending s. 287.042, F.S.; limiting the duties of the Department of

4-00922C-12 20121626__

Management Services to the procurement of commodities and contractual services; directing the department to develop a list of interested vendors; deleting provisions requiring that the department perform duties relating to procurement and contracting policies and procedures; creating s. 287.044, F.S.; assigning duties relating to procurement and contracting policies and procedures to the Department of Financial Services; requiring the department to develop a list of vendors not allowed to do business with the state; requiring the department to review and approve contracts in accordance with rules adopted by the department; providing that the department have authority to waive procedures under certain circumstances; providing that the department have flexibility in accomplishing its duties and responsibilities including the use of different contracting methods on a pilot basis; amending s. 287.057, F.S.; revising the list of contractual services and commodities that are exempt from competitive solicitation to delete certain services from the exemption; revising provisions prohibiting an agency from dividing a solicitation; authorizing an agency to purchase commodities or services through another agency's contract; amending s. 287.058, F.S.; requiring contracts to include a performance measure for each deliverable; creating s. 287.1312, F.S.; requiring certification of contract managers by the Department of Financial Services for contracts of more

than a certain amount; requiring the training program for the certification to provide training in certain areas; authorizing the department to adopt rules to administer the program; amending s. 287.133, F.S.; revising the definition of "department" to mean the Department of Financial Services rather than the Department of Management Services with respect to provisions governing public entity crimes and placement on the convicted vendor list; amending ss. 255.25, 287.012, 402.7305, 427.0135, and 946.515, F.S.; conforming cross-references; providing state policies with regards to procurement and requiring the Chief Financial Officer to conduct a study of current procurement laws pursuant to such policies; requiring that the Chief Financial Officer submit a report to the Legislature and Governor by a certain date on such study; repealing ch. 287, F.S., on a future date; providing an appropriation; providing an effective date.

WHEREAS, during the 2010-2011 fiscal year, the state spent nearly $51 billion, or approximately 57 percent, of the state budget on contracts and agreements for goods and services, and

WHEREAS, during the same fiscal year, the Department of Financial Services reviewed 364 contract and grant agreements, each valued at $1 million or more, and found that 26 percent had significant deficiencies in their scope of work, deliverables, or performance standards, and

WHEREAS, if this 26 percent error rate applied to the total

contractual amount spent during the fiscal year, approximately $13 billion in taxpayer dollars was obligated to poorly written contracts, and

WHEREAS, the state does not have uniform standards for state contracts which incorporate a comprehensive and precise scope of work, clearly defined deliverables, and minimum performance standards that include financial consequences for failing to deliver goods and services, and

WHEREAS, the Legislature believes that there is an acute need to initiate reforms that ensure that the state contracting process reflects the highest ethical and fiscal standards; is clear, consistent, and measurable; and is conducted in the most efficient manner possible while delivering goods and services to state residents, and

WHEREAS, the Legislature recognizes that the poor management of a good contract could lead to the waste and misuse of tax dollars, and

WHEREAS, the Legislature believes that state residents deserve to receive the goods and services for which they are paying, and

WHEREAS, the Legislature also believes that this state is a business-friendly state where people doing business with the state provide goods and services in good faith and deserve to know what is expected of them, and

WHEREAS, there remains an acute need to provide greater transparency and accountability in public transactions, and

WHEREAS, the Legislature supports additional high-level training and certification of state contract managers, especially as it relates to contracts valued at $325,000 or

more, and

WHEREAS, the Legislature believes that a thorough review of the state's procurement system to evaluate its efficiency and effectiveness has not been performed for many years, and

WHEREAS, the Legislature has determined that the Chief Financial Officer should conduct an evaluation of the state procurement process of the executive branch of government, and

WHEREAS, the Legislature fully supports promoting the value, integrity, transparency, accountability of, and the public confidence in, the state's procurement and contracting processes, NOW, THEREFORE,

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

Section 1. Paragraphs (a) and (i) of subsection (7) of section 11.45, Florida Statutes, are amended to read:

11.45 Definitions; duties; authorities; reports; rules.—

(7) AUDITOR GENERAL REPORTING REQUIREMENTS.—

(a) The Auditor General must ~~shall~~ notify the Legislative Auditing Committee of any local governmental entity, district school board, charter school, or charter technical career center that does not comply with the reporting requirements of s. 215.985 or s. 218.39.

(i) Beginning in 2012, the Auditor General shall annually transmit by July 15, to the President of the Senate, the Speaker of the House of Representatives, and the Department of Financial Services, a list of all school districts, charter schools, charter technical career centers, Florida College System institutions, state universities, and water management districts

that have failed to comply with the transparency requirements of s. 215.985 as identified in the audit reports reviewed pursuant to paragraph (b) and those conducted pursuant to subsection (2).

Section 2. Section 215.971, Florida Statutes, is amended to read:

215.971 Agreements funded with federal and state assistance.—

(1) For an agency agreement that provides state financial assistance to a recipient or subrecipient, as those terms are defined in s. 215.97, or that provides federal financial assistance to a subrecipient, as defined by applicable United States Office of Management and Budget circulars, the agreement must ~~shall~~ include a provision:

(a) ~~(1)~~ ~~A provision~~ Specifying a scope of work that clearly establishes the tasks that the recipient or subrecipient is required to perform; and

(b) ~~(2)~~ ~~A provision~~ Dividing the agreement into quantifiable units of deliverables which ~~that~~ must be received and accepted in writing by the agency before payment. Each deliverable must be directly related to the scope of work and ~~must~~ specify a performance measure. As used in this paragraph, the term "performance measure" means the required minimum level of service to be performed and the criteria for evaluating the successful completion of each deliverable.

(2) Before execution, agreements to be funded with state or federal financial assistance must be submitted for review and approval in accordance with rules adopted by the Department of Financial Services. The review must ensure that the agreement document contains a clear statement of work, quantifiable and

measureable deliverables, performance measures, and financial consequences for nonperformance. An agreement that does not comply with this subsection may be rejected and returned to the submitting agency for revision.

(3) For each agreement funded with federal or state assistance, the contracting agency shall designate an employee to function as grant manager who shall be responsible for enforcing performance of the agreement terms and conditions and serve as a liaison with the recipient. A grant manager who is responsible for one or more agreements in excess of the threshold amount provided in s. 287.017 for CATEGORY FIVE must be certified under s. 287.1312. The Chief Financial Officer shall establish and disseminate uniform procedures for payment requests pursuant to s. 17.03(3) to ensure that services are rendered in accordance with the agreement terms before the agency processes an invoice for payment. The procedures must include, but need not be limited to, procedures for monitoring and documenting a recipient's performance, reviewing and documenting all deliverables for which payment is requested by the recipient, and providing written certification by the grant manager of the agency's receipt of goods and services.

Section 3. Subsection (16) of section 215.985, Florida Statutes, is amended to read:

215.985 Transparency in government spending.—

(16) The Chief Financial Officer shall establish a secure, shared, intergovernmental contract tracking ~~provide public access to a state contract management~~ system.

(a) Within 30 calendar days after executing a contract, each state agency as defined in s. 216.011(1), and, effective

October 1, 2013, each local governmental entity and independent special district as defined in s. 218.31, each district school board as described in s. 1001.32, the Board of Governors of the State University System as described in s. 1001.70, and each Florida College System institution board of trustees as described in s. 1001.61 must post the following ~~that provides~~ information and documentation relating to that contract on the contract tracking system: ~~contracts procured by governmental entities.~~

1. The name of the contracting entities;

2. The procurement method;

3. The contract beginning and ending dates;

4. The nature or type of the commodities or services purchased;

5. Applicable contract unit prices and deliverables;

6. Total compensation to be paid or received under the contract;

7. All payments made to the contract vendor to date;

8. All commodities or services received from the contract vendor to date;

9. Applicable contract performance measures;

10. Contract extensions or renewals, if any;

11. The justification for not using competitive solicitation to procure the contract, including citation to any statutory exemption or exception from competitive solicitation, if applicable;

12. Electronic copies of the contract and procurement documents, including any provision that may have been redacted to conceal exempt or confidential information; and

13. Any other information regarding the contract or the procurement which may be required by the Department of Financial Services.

~~(a) The data collected in the system must include, but need not be limited to, the contracting agency; the procurement method; the contract beginning and ending dates; the type of commodity or service; the purpose of the commodity or service; the compensation to be paid; compliance information, such as performance metrics for the service or commodity; contract violations; the number of extensions or renewals; and the statutory authority for providing the service.~~

(b) Within 30 calendar days after a major modification or amendment ~~change~~ to an existing contract~~, or the execution of a new contract, agency procurement staff of~~ the affected ~~state governmental~~ entity must ~~shall~~ update the ~~necessary~~ information described in paragraph (a) in the ~~state~~ contract tracking ~~management~~ system. A major modification or amendment ~~change~~ to a contract includes, but is not limited to, a renewal, termination, or extension of the contract, or an amendment to the contract as determined by the Chief Financial Officer.

(c) Each entity identified in paragraph (a) must redact, as defined in s. 119.011, any exempt or confidential information, including trade secrets as defined in s. 688.002 or s. 812.081, from the contract or procurement documents before posting an electronic copy of such documents on the contract tracking system.

1. If an entity becomes aware that an electronic copy of a contract or procurement document that it posted has not been properly redacted, the entity must replace the electronic copy

of the documents with a redacted copy.

2. If a party to a contract, or an authorized representative thereof, discovers that an electronic copy of a contract or procurement document on the system has not been properly redacted, the party or representative may request the entity that posted the document to redact the exempt or confidential information. Upon receipt of a request in compliance with this subparagraph, the entity that posted the document shall redact the exempt or confidential information.

a. Such request must be in writing and delivered by mail, facsimile, or electronic transmission, or in person to the entity that posted the information. The request must identify the specific document, the page numbers that include the exempt or confidential information, the information that is exempt or confidential, and the relevant statutory exemption. A fee may not be charged for a redaction made pursuant to such request.

b. If necessary, a party to the contract may petition the circuit court for an order directing compliance with this paragraph.

3. The Chief Financial Officer, the Department of Financial Services, or any officer, employee, or contractor thereof, is not responsible for redacting exempt or confidential information from an electronic copy of a contract or procurement document posted by another entity on the system, and is not liable for the failure of the entity to redact the exempt or confidential information. The Department of Financial Services may notify the posting entity if it discovers that a document posted on the tracking system contains exempt or confidential information.

(d) Pursuant to ss. 119.01 and 119.07, the Chief Financial

Officer may make information posted on the contract tracking system available for viewing and downloading by the public through a secure website. Unless otherwise provided by law, information retrieved electronically pursuant to this paragraph is not admissible in court as an authenticated document.

1. The Chief Financial Officer may regulate and prohibit the posting of records that could facilitate identity theft or fraud, such as signatures; compromise or reveal an agency investigation; reveal the identity of undercover personnel; reveal proprietary confidential business information or trade secrets; reveal an individual's medical information; or reveal any other record or information that the Chief Financial Officer believes may jeopardize the health, safety, or welfare of the public. However, such prohibition does not eliminate the duty of an entity to provide a copy of a public record upon request. The Chief Financial Officer shall use appropriate Internet security measures to ensure that no person has the ability to alter or modify records available on the website.

2. Records made available on the website, including electronic copies of contracts or procurement documents, may not reveal information made exempt or confidential by law. Notice of the right of an affected party to request redaction of exempt or confidential information pursuant to paragraph (c) must be conspicuously and clearly displayed on the website. This includes, but is not limited to:

a. Criminal intelligence or criminal investigative information as defined in s. 119.011;

b. Surveillance techniques or procedures or personnel;

c. The identity of a confidential informant or confidential

source;

d. The identify of undercover personnel of a criminal justice agency;

e. A security system plan; or

f. Trade secret as defined in s. 688.002 or s. 812.081.

(e) The posting of information on the contract tracking system or the provision of contract information on a website for public viewing and downloading does not eliminate the duty of an entity to respond to a public record request for such information or to a subpoena for such information.

1. A request for a copy of a contract or procurement document or a certified copy of a contract or procurement document shall be made to the entity that is party to the contract and that maintains the original documents. Such request may not be made to the Chief Financial Officer or the Department of Financial Services or any officer, employee, or contractor thereof unless the Chief Financial Officer or the department is a party to the contract.

2. A subpoena for a copy of a contract or procurement document or certified copy of a contract or procurement document must be served on the entity that is a party to the contract and that maintains the original documents. The Chief Financial Officer or the Department of Financial Services or any officer, employee, or contractor thereof may not be served a subpoena for those records unless the Chief Financial Officer or the department is a party to the contract.

(f) The Department of Financial Services may adopt rules to administer this subsection.

Section 4. Section 216.0111, Florida Statutes, is repealed.

Section 5. Section 287.032, Florida Statutes, is amended to read:

287.032 Departmental responsibility ~~purpose of department~~.—Pursuant to the administration of this chapter:

(1) ~~It shall be~~ The responsibility ~~purpose~~ of the Department of Management Services is to:

(a) ~~(1) To~~ Promote efficiency, economy, and the conservation of energy and coordinate ~~to effect coordination in~~ the purchase of commodities and contractual services for the state.

~~(2) To provide uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users.~~

(b) ~~(3) To~~ Procure and distribute federal surplus tangible personal property allocated to the state by the Federal Government.

(2) The responsibility of the Department of Financial Services is to:

(a) Provide uniform commodity and contractual service procurement policies, rules, procedures, and forms for use by agencies and eligible users.

(b) Monitor agencies with respect to compliance with established policies, rules, and procedures.

Section 6. Section 287.042, Florida Statutes, is amended to read:

287.042 Powers, duties, and functions of the Department of Management Services.—The department is responsible for the procurement of commodities and contractual services for agencies and has ~~shall have~~ the following powers, duties, and functions:

(1) ~~(a) To~~ canvass all sources of supply, establish and

maintain a vendor list, and contract for the purchase, lease, or acquisition, including purchase by installment sales or lease-purchase contracts which may provide for the payment of interest on unpaid portions of the purchase price, of all commodities and contractual services required by an ~~any~~ agency under this chapter. A ~~Any~~ contract providing for deferred payments and the payment of interest is ~~shall be~~ subject to specific rules adopted by the Department of Financial Services.

(a) ~~(b)~~ The department shall develop a list of interested vendors to be maintained by classes of commodities and contractual services. The list may not be used to prequalify a vendor or to exclude an interested vendor from bidding. However, a vendor barred by the Chief Financial Officer pursuant to s. 287.044(7) may not be included on the list. The department may remove from the ~~its~~ vendor list any source of supply which fails to fulfill any of its duties specified in a contract with the state. The department ~~It~~ may reinstate ~~any~~ such source of supply if the department ~~when it~~ is satisfied that further instances of default will not occur.

(b) ~~(c)~~ In order to promote the cost-effective procurement of commodities and contractual services, the department or an agency may enter into contracts that limit the liability of a vendor consistent with s. 672.719.

~~(d) The department shall issue commodity numbers for all products of the corporation operating the correctional industry program which meet or exceed department specifications.~~

(c) ~~(c)~~ The department shall include the products offered by the corporation operating the correctional industry program on any listing prepared by the department which lists state term

contracts executed by the department. The products or services shall be placed on such list in a category based upon specification criteria developed through a joint effort of the department and the corporation and approved by the department.

1.~~(f)~~ The corporation may submit products and services to the department for testing, analysis, and review relating to the quality and cost comparability. If, after review and testing, the department approves ~~of~~ the products and services, the department shall give written notice ~~thereof~~ to the corporation. The corporation shall pay a reasonable fee ~~charged~~ for the testing of its products by the Department of Agriculture and Consumer Services.

2. The department shall issue a commodity number for all products of the corporation which meet or exceed department specifications.

(d)~~(g)~~ The department shall include products and services that are offered by a qualified nonprofit agency for the blind or for the other severely handicapped ~~organized pursuant to chapter 413~~ and that have been determined to be suitable for purchase pursuant to s. 413.035 on a ~~any~~ department listing of state term contracts. The products and services shall be placed on such list in a category based upon specification criteria developed by the department in consultation with the ~~qualified~~ nonprofit agency.

(e)~~(h)~~ The department may collect fees for the use of its electronic information services. The fees may be imposed on an individual transaction basis or as a fixed subscription for a designated period of time. At a minimum, the fees shall be determined in an amount sufficient to cover the department's

projected costs for ~~of~~ the services, including overhead, in accordance with the policies of the department ~~of Management Services~~ for computing its administrative assessment. All fees collected under this paragraph shall be deposited in the Operating Trust Fund for disbursement as provided by law.

(2)~~(a)~~ To establish purchasing agreements and procure state term contracts for commodities and contractual services, pursuant to s. 287.057, under which state agencies shall, and eligible users may, make purchases pursuant to s. 287.056.

(a) The department may restrict purchases by ~~from some term contracts to~~ state agencies from ~~only for those~~ term contracts if ~~where~~ the inclusion of other governmental entities will have an adverse effect on competition or on ~~to those~~ federal facilities located in this state. In such planning or purchasing, the office ~~of Supplier Diversity~~ may monitor to ensure that opportunities are afforded for contracting with minority business enterprises. The department, for state term contracts, and all agencies, for multiyear contractual services or term contracts, shall explore reasonable and economical means to use ~~utilize~~ certified minority business enterprises. Purchases by any county, municipality, private nonprofit community transportation coordinator designated pursuant to chapter 427~~, while~~ conducting business related solely to the Commission for the Transportation Disadvantaged, or other local public agency under the provisions in the state purchasing contracts, and purchases, from the corporation operating the correctional work programs, of products or services that are subject to paragraph (1)(c) ~~(1)(f)~~, are exempt from the competitive solicitation requirements otherwise applying to

their purchases.

(b) As an alternative to ~~any provision in~~ s. 120.57(3)(c), the department may proceed with the competitive solicitation or contract award process of a term contract if ~~when~~ the secretary of the department or his or her designee sets forth in writing particular facts and circumstances that ~~which~~ demonstrate that the delay incident to staying the solicitation or contract award process would be detrimental to the interests of the state. If, after the award of the ~~a~~ contract resulting from a competitive solicitation in which a timely protest was received and in which the state did not prevail, the contract may be canceled and reawarded.

(c) Any person who files an action protesting a decision or intended decision pertaining to contracts administered by the department, a water management district, or an agency pursuant to s. 120.57(3)(b) shall, at the same time, also post a bond equal to 1 percent of the estimated contract amount with, and payable to, the department, the water management district, or the agency, as applicable ~~at the time of filing the formal written protest a bond payable to the department, the water management district, or agency in an amount equal to 1 percent of the estimated contract amount~~. For protests of decisions or intended decisions pertaining to exceptional purchases, the bond must ~~shall be in an amount~~ equal ~~to~~ 1 percent of the estimated contract amount for the exceptional purchase.

1. The estimated contract amount shall be based upon the contract price submitted by the protestor or, if no contract price was submitted, the department, water management district, or agency shall estimate the contract amount based on factors,

including, but not limited to, the price of previous or existing contracts for similar commodities or contractual services, the amount appropriated by the Legislature for the contract, or the fair market value of similar commodities or contractual services. The agency shall provide the estimated contract amount to the vendor within 72 hours, excluding Saturdays, Sundays, and state holidays, after the filing of the notice of protest by the vendor. The estimated contract amount is not subject to protest pursuant to s. 120.57(3).

2. The bond shall be conditioned upon the payment of all costs and charges that are adjudged against the protestor in the administrative hearing in which the action is brought and in any subsequent appellate court proceeding.

3. In lieu of a bond, the department, ~~the~~ water management district, or agency may~~, in either case,~~ accept a cashier's check, official bank check, or money order in the amount of the bond.

4. If, after completion of the administrative hearing process and any appellate court proceedings, the department, water management district, or agency prevails, it shall recover all costs and charges, which must ~~shall~~ be included in the final order or judgment, excluding attorney ~~attorney's~~ fees. ~~This section shall not apply to protests filed by the Office of Supplier Diversity.~~ Upon payment of such costs and charges by the protestor, the bond, cashier's check, official bank check, or money order shall be returned to the protestor. If, after the completion of the administrative hearing process and any appellate court proceedings, the protestor prevails, the protestor may ~~shall~~ recover from the department, water

management district, or agency all costs and charges that are ~~which shall be~~ included in the final order or judgment, excluding attorney ~~attorney's~~ fees.

5. This paragraph does not apply to protests filed by the office.

~~(3) To establish a system of coordinated, uniform procurement policies, procedures, and practices to be used by agencies in acquiring commodities and contractual services, which shall include, but not be limited to:~~

~~(a) Development of a list of interested vendors to be maintained by classes of commodities and contractual services. This list shall not be used to prequalify vendors or to exclude any interested vendor from bidding.~~

~~(b)1. Development of procedures for advertising solicitations. These procedures must provide for electronic posting of solicitations for at least 10 days before the date set for receipt of bids, proposals, or replies, unless the department or other agency determines in writing that a shorter period of time is necessary to avoid harming the interests of the state. The Office of Supplier Diversity may consult with the department regarding the development of solicitation distribution procedures to ensure that maximum distribution is afforded to certified minority business enterprises as defined in s. 288.703.~~

~~2. Development of procedures for electronic posting. The department shall designate a centralized website on the Internet for the department and other agencies to electronically post solicitations, decisions or intended decisions, and other matters relating to procurement.~~

~~(c) Development of procedures for the receipt and opening of bids, proposals, or replies by an agency. Such procedures shall provide the Office of Supplier Diversity an opportunity to monitor and ensure that the contract award is consistent with the requirements of s. 287.09451.~~

~~(d) Development of procedures to be used by an agency in deciding to contract, including, but not limited to, identifying and assessing in writing project needs and requirements, availability of agency employees, budgetary constraints or availability, facility equipment availability, current and projected agency workload capabilities, and the ability of any other state agency to perform the services.~~

~~(e) Development of procedures to be used by an agency in maintaining a contract file for each contract which shall include, but not be limited to, all pertinent information relating to the contract during the preparatory stages; a copy of the solicitation; documentation relating to the solicitation process; opening of bids, proposals, or replies; evaluation and tabulation of bids, proposals, or replies; and determination and notice of award of contract.~~

~~(f) Development of procedures to be used by an agency for issuing solicitations that include requirements to describe commodities, services, scope of work, and deliverables in a manner that promotes competition.~~

~~(g) Development of procedures to be used by an agency when issuing requests for information and requests for quotes.~~

~~(h) Development of procedures to be used by state agencies when procuring information technology commodities and contractual services that ensure compliance with public records~~

~~requirements and records retention and archiving requirements.~~

~~(4)(a) To prescribe the methods of securing competitive sealed bids, proposals, and replies. Such methods may include, but are not limited to, procedures for identifying vendors; setting qualifications; conducting conferences or written question and answer periods for purposes of responding to vendor questions; evaluating bids, proposals, and replies; ranking and selecting vendors; and conducting negotiations.~~

~~(b) To prescribe procedures for procuring information technology and information technology consultant services that provide for public announcement and qualification, competitive solicitations, contract award, and prohibition against contingent fees. Such procedures are limited to information technology consultant contracts for which the total project costs, or planning or study activities, are estimated to exceed the threshold amount provided in s. 287.017, for CATEGORY TWO.~~

(3) ~~(5)~~ To prescribe specific commodities and quantities to be purchased locally.

~~(6)(a) To govern the purchase by any agency of any commodity or contractual service and to establish standards and specifications for any commodity.~~

(4) ~~(b)~~ Except for the purchase of insurance, to ~~the department may~~ delegate to agencies the authority for the procurement of and contracting for commodities or contractual services.

~~(7) To establish definitions and classes of commodities and contractual services. Agencies shall follow the definitions and classes of commodities and contractual services established by the department in acquiring or purchasing commodities or~~

~~contractual services. The authority of the department under this section shall not be construed to impair or interfere with the determination by state agencies of their need for, or their use of, services including particular specifications.~~

~~(8) To provide any commodity and contractual service purchasing rules to the Chief Financial Officer and all agencies through an electronic medium or other means. Agencies may not approve any account or request any payment of any account for the purchase of any commodity or the procurement of any contractual service covered by a purchasing or contractual service rule except as authorized therein. The department shall furnish copies of rules adopted by the department to any county, municipality, or other local public agency requesting them.~~

(5) ~~(9)~~ To require that every agency furnish information relative to its commodity and contractual services purchases and methods of purchasing commodities and contractual services to the department when so requested.

(6) ~~(10)~~ To prepare statistical data concerning the method of procurement, terms, usage, and disposition of commodities and contractual services by agencies. All agencies shall furnish such information for this purpose to the office and to the department, as the department or office may call for, but at least ~~no less frequently than~~ annually, on such forms or in such manner as the department may prescribe.

~~(11) To establish and maintain programs for the purpose of disseminating information to government, industry, educational institutions, and the general public concerning policies, procedures, rules, and forms for the procurement of commodities and contractual services.~~

(7) ~~(12)~~ Except as otherwise provided in this section ~~herein~~, to adopt rules necessary to carry out the purposes of this section, including the authority to delegate to any agency any and all of the responsibility conferred by this section, retaining to the department any and all authority for supervision thereof. Such purchasing of commodities and procurement of contractual services by state agencies must also ~~shall~~ be in strict accordance with the rules and procedures prescribed by the Department of Financial Services.

(8) ~~(13)~~ If the department determines in writing that it is in the best interest of the state, to award to multiple suppliers contracts for commodities and contractual services established by the department for use by all agencies. Such awards may be on a statewide or regional basis. If regional contracts are established by the department, multiple supplier awards may be based upon multiple awards for regions. Agencies may award contracts to a responsible and responsive vendor on a statewide or regional basis.

(9) ~~(14)~~ To procure and distribute federal surplus tangible personal property allocated to the state by the Federal Government.

(10) ~~(15)~~ To enter into joint agreements with governmental agencies, as defined in s. 163.3164, for the purpose of pooling funds for the purchase of commodities or information technology that can be used by multiple agencies.

(a) Each agency that has been appropriated or has existing funds for such purchase, shall, upon contract award by the department, transfer their portion of the funds into the department's Operating Trust Fund for payment by the department.

The funds shall be transferred by the Executive Office of the Governor pursuant to the agency budget amendment request provisions in chapter 216.

(b) Agencies that sign the joint agreements are financially obligated for their portion of the agreed-upon funds. If an agency becomes more than 90 days delinquent in paying the funds, the department shall certify to the Chief Financial Officer the amount due, and the Chief Financial Officer shall transfer the amount due to the Operating Trust Fund of the department from any of the agency's available funds. The Chief Financial Officer shall report these transfers and the reasons for the transfers to the Executive Office of the Governor and the legislative appropriations committees.

(11) ~~(16)~~ To evaluate contracts let by the Federal Government, another state, or a political subdivision for the provision of commodities and contract services, and, if it is determined in writing to be cost-effective and in the best interest of the state, to enter into a written agreement authorizing an agency to make purchases under such contract.

(12) ~~(17)(a)~~ To enter into contracts pursuant to chapter 957 for the designing, financing, acquiring, leasing, constructing, or operating of private correctional facilities. The department shall enter into such ~~a contract or~~ contracts with one contractor per facility ~~for the designing, acquiring, financing, leasing, constructing, and operating of that facility~~ or may, if specifically authorized by the Legislature, separately contract for each of ~~any~~ such services.

(a) ~~(b)~~ The department shall also ~~To~~ manage and enforce compliance with existing or future contracts entered into

pursuant to chapter 957.

(b) The department may not delegate the responsibilities conferred by this subsection.

Section 7. Section 287.044, Florida Statutes, is created to read:

287.044 Powers, duties, and functions of the Department of Financial Services.—The Department of Financial Services is responsible for establishing and enforcing procurement and contracting policies and procedures for the Department of Management Services and all agencies. The Department of Financial Services has the following powers, duties, and functions:

(1) To establish a system of coordinated and uniform procurement policies, procedures, and practices to be used by agencies when acquiring commodities and contractual services, which includes, but is not limited to:

(a) The development of procedures to be used by an agency for issuing or advertising solicitations which include requirements for the agency to describe commodities, services, scope of work, and deliverables in a manner that promotes competition.

1. Such procedures must provide for electronic posting of solicitations at least 10 days before the date set for receipt of bids, proposals, or replies, unless the agency determines in writing that a shorter period of time is necessary to avoid harming the interests of the state.

2. The office may consult with the department regarding the development of solicitation distribution procedures to ensure that maximum distribution is afforded to certified minority

business enterprises as defined in s. 288.703.

3. The department shall designate a centralized website on the Internet for the department and other agencies to electronically post solicitations, decisions or intended decisions, and other matters relating to procurement.

4. State agencies shall be prepared to provide an explanation to unsuccessful bidders, if requested, of the reasons for which the bidders did not win a bid, in order to improve the bidders' chances for future success and encourage greater competition in the marketplace.

(b) The development of procedures to be used by an agency when issuing requests for information and requests for quotes.

(c) The development of procedures to be used by state agencies when procuring information technology commodities and contractual services which ensure compliance with public records requirements and records retention and archiving requirements.

(d) The development of procedures for the receipt and opening of bids, proposals, or replies by an agency. Such procedures must provide the office an opportunity to monitor and to ensure that the contract award is consistent with the requirements of s. 287.09451.

(e) The development of procedures to be used by an agency in deciding to contract, including, but not limited to, identifying and assessing in writing project needs and requirements, availability of agency employees, budgetary availability or constraints, availability of facility equipment, current and projected agency workload capabilities, and the ability of another state agency to perform the services.

(f) The development of a methodology to calculate cost

savings or cost avoidance achieved under a contract. Each agency must annually report any action taken and the amount of cost savings or cost avoidance which resulted from using the methodology developed by the department. At a minimum, the methodology should address:

1. The assessment of financial consequences for nonperformance.

2. Criteria for renegotiating the contract.

3. Refinement of the scope of work or deliverables.

4. The use of additional competition during the procurement process which results in awarding the contract at a lower price than the previous award.

(g) The development of procedures for recording and maintaining support documentation for a cost or price analysis to be performed before the award of a contract in excess of the threshold amount provided in s. 287.017 for CATEGORY FOUR. The cost or price analysis shall be used to validate the reasonableness of bids, proposals, or replies.

(h) The development of procedures to be used by state agencies when entering into contracts which ensure standard formats, quantifiable and measurable deliverables, performance measures, and financial consequences for nonperformance.

(i) The development of procedures to be used by an agency in maintaining a contract file for each contract which includes, but is not limited to, all pertinent information relating to the contract during the preparatory stages; the solicitation process, including a copy of the solicitation; the opening of bids, proposals, or replies; the evaluation and tabulation of bids, proposals, or replies; and the determination and notice of

contract award.

(2) To prescribe the methods of securing competitive sealed bids, proposals, and replies. Such methods may include, but are not limited to, procedures for identifying vendors; setting qualifications; conducting conferences or written question and answer periods for purposes of responding to vendor questions; evaluating bids, proposals, and replies; ranking and selecting vendors; and conducting negotiations.

(3) To prescribe procedures for procuring information technology and information technology consultant services which provide for public announcement and qualification, competitive solicitations, the contract award, and a prohibition against contingent fees. Such procedures are limited to information technology consultant contracts for which the total project costs, or planning or study activities, are estimated to exceed the threshold amount provided in s. 287.017 for CATEGORY TWO.

(4) To govern the purchase by an agency of any commodity or contractual service and to establish standards and specifications for a commodity. The Chief Financial Officer shall establish definitions and classes of commodities and contractual services which agencies must adhere to in acquiring or purchasing commodities or contractual services. The department's authority under this section may not impair or interfere with an agency's determination of its need for, or use of, services that include particular specifications.

(5) To provide to agencies through an electronic medium or other means rules for purchasing commodities and contractual services. Agencies may not approve any account, or request payment of any account, for the purchase of any commodity or the

procurement of any contractual service covered by a purchasing or contractual service rule except as authorized by such rule. The department shall furnish copies of rules adopted by the department to any county, municipality, or other local public agency requesting them.

(6) To establish and maintain programs that disseminate information to governmental entities, industry vendors, educational institutions, and the general public concerning policies, procedures, rules, and forms for the procurement of commodities and contractual services.

(7) To establish and maintain a list of vendors that are not allowed to do business with the state pursuant to ss. 287.132(4) and 287.133. The department may add to the list vendors that are not compliant with federal or state laws, or that the department determines have uncollected accounts that are owed to the state.

(8) To review and approve contracts subject to this chapter before the execution of such contracts in accordance with rules adopted by the department. The review must ensure that all contracting laws have been met; that the contract document contains a clear statement of work, quantifiable and measureable deliverables, performance measures, financial consequences for nonperformance, and clear terms and conditions that protect the interests of the state; that documentation is available to support the contract; and that the associated costs of the contract are not unreasonable or inappropriate. A contract that does not comply with this subsection may be rejected and returned to the submitting agency for revision.

(a) For contracts in excess of the threshold amount

provided in s. 287.017 for CATEGORY THREE, the review must include, but need not be limited to:

1. Evidence of advertising the procurement opportunity, if applicable;

2. The bid, proposal, or reply itself, whether an invitation to bid, request for proposals, or invitation to negotiate, as applicable;

3. The preprocurement conference questions and answers;

4. Any additional documentation provided to bidders, proposers, or repliers;

5. The list of bidders, proposers, or repliers solicited;

6. The evaluation instrument and process description related to the contract;

7. The bid tabulation or evaluation record;

8. Documentation that supports the agency's determination of vendor responsibility;

9. The successful bid, proposal, or reply in addition to the unsuccessful bids, proposals, or replies;

10. Documentation that supports the selection of the contractor;

11. The reasonableness of the price;

12. Verification that all statutory and regulatory requirements have been met; and

13. The proposed contract.

(b) The department shall verify that a competitive process was used if required by law and that the contract was appropriately awarded on the basis of lowest price or best value to a responsive and reasonable bidder, proposer, or replier. For contracts not competitively awarded, the procurement record

shall be reviewed for restrictive specifications and the agency's justification for the noncompetitive method used in awarding the contract, including justification for the selection of the vendor and the reasonableness of the terms.

(c) The department has 90 days to make a final determination regarding approval of a contract. The department and the agency entering into the contract may agree to a longer review period to ensure the thorough consideration of the procurement process and its results.

(d) In order to ensure that the parties to the contract are aware that a contract is not effective unless approved by the department, the following language must be included in each state contract or amendment to such contract:

If this contract, or an amendment to a contract, is valued at or greater than $65,000 or if the state agrees to give something other than money, which consideration has a value or reasonably estimated value at or greater than $35,000, the contract or amendment is not valid, effective, or binding upon the state unless the contract or amendment has been approved by the Chief Financial Officer.

(e) Contracts and grants or grants-type contracts must be treated similarly. Therefore, if a for-profit entity joins the competition for a grant, normal contract rules apply even though they may not be appropriate for a grant procurement.

(9) To waive minor deviations from current procedures in order to prevent a delay in awarding an otherwise favorable

contract if a vendor is not adversely affected and current law is not violated. The Chief Financial Officer shall provide recommendations to the Legislature to resolve such deviations, where appropriate, at the next regular legislative session.

(10) To have flexibility in accomplishing the intent of this section. If situations arise that current law does not anticipate, the department may work with state agencies to use different contracting methods on a pilot basis for the remainder of the calendar year. The Chief Financial Officer must provide recommendations to the Legislature to resolve such situations, where appropriate, at the next regular legislative session.

Section 8. Paragraph (f) of subsection (3), subsection (9), and subsection (14) of section 287.057, Florida Statutes, are amended, and subsection (24) is added to that section, to read:

287.057 Procurement of commodities or contractual services.—

(3) When the purchase price of commodities or contractual services exceeds the threshold amount provided in s. 287.017 for CATEGORY TWO, no purchase of commodities or contractual services may be made without receiving competitive sealed bids, competitive sealed proposals, or competitive sealed replies unless:

(f) The following contractual services and commodities are not subject to the competitive-solicitation requirements of this section:

~~1. Artistic services. For the purposes of this subsection, the term "artistic services" does not include advertising or typesetting. As used in this subparagraph, the term "advertising" means the making of a representation in any form~~

~~in connection with a trade, business, craft, or profession in order to promote the supply of commodities or services by the person promoting the commodities or contractual services.~~

~~2. Academic program reviews if the fee for such services does not exceed $50,000.~~

~~3. Lectures by individuals.~~

1.~~4.~~ Legal services, including attorney, paralegal, expert witness, appraisal, or mediator services.

2.~~5.a.~~ Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration, and, ~~.~~

~~b.~~ beginning January 1, 2011, health services, including, but not limited to, substance abuse and mental health services~~,~~ involving examination, diagnosis, treatment, prevention, or medical consultation, if ~~when~~ such services are offered to eligible individuals participating in a specific program that qualifies multiple providers and uses a standard payment methodology. Reimbursement of administrative costs for providers of services purchased in this manner are ~~shall~~ also ~~be~~ exempt. For purposes of this subparagraph ~~sub-subparagraph~~, the term "providers" means health professionals, health facilities, or organizations that deliver or arrange for the delivery of health services.

3.~~6.~~ Services provided to persons with mental or physical disabilities by not-for-profit corporations that ~~which~~ have obtained exemptions under ~~the provisions of~~ s. 501(c)(3) of the United States Internal Revenue Code or if ~~when~~ such services are governed by the provisions of Office of Management and Budget Circular A-122. However, in acquiring such services, the agency

must ~~shall~~ consider the vendor's ability ~~of the vendor~~, past performance, willingness to meet time requirements, and price.

4.~~7.~~ Medicaid services delivered to an eligible Medicaid recipient, unless the agency is directed otherwise in law.

5.~~8.~~ Family placement services.

6.~~9.~~ Prevention services related to mental health, including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways, operated by not-for-profit corporations. However, in acquiring such services, the agency must ~~shall~~ consider the vendor's ability ~~of the vendor~~, past performance, willingness to meet time requirements, and price.

~~10. Training and education services provided to injured employees pursuant to s. 440.491(6).~~

7.~~11.~~ Contracts entered into pursuant to s. 337.11.

8.~~12.~~ Services or commodities provided by governmental agencies.

(9) An agency may ~~shall~~ not divide the solicitation of commodities or contractual services so as to avoid the requirements of subsections (1)-(3) and reduce the ability of businesses to openly compete. For the purposes of this subsection, state agencies shall consider all purchases of the same commodity or service during one year to be part of a single purchase.

(14) For each contractual services contract, the agency shall designate an employee to function as contract manager who shall be responsible for enforcing performance of the contract terms and conditions and serve as a liaison with the contractor. Each contract manager who is responsible for one or more contracts in excess of the threshold amount provided under s.

287.017 for CATEGORY FIVE ~~TWO~~ must be certified pursuant to s. 287.1312 ~~attend training conducted by the Chief Financial Officer for accountability in contracts and grant management~~. The Chief Financial Officer shall establish and disseminate uniform procedures pursuant to s. 17.03(3) to ensure that contractual services have been rendered in accordance with the contract terms before the agency processes the invoice for payment. The procedures must ~~shall~~ include, but need not be limited to, procedures for monitoring and documenting contractor performance, reviewing and documenting all deliverables for which payment is requested by vendors, and providing written certification by contract managers of the agency's receipt of goods and services.

(24) An agency may purchase commodities or services through another agency's existing contract rather than through competitive competition if the use of such contract is in the best interest of the state.

Section 9. Paragraph (e) of subsection (1) of section 287.058, Florida Statutes, is amended to read:

287.058 Contract document.—

(1) Every procurement of contractual services in excess of the threshold amount provided in s. 287.017 for CATEGORY TWO, except for the providing of health and mental health services or drugs in the examination, diagnosis, or treatment of sick or injured state employees or the providing of other benefits as required by the provisions of chapter 440, shall be evidenced by a written agreement embodying all provisions and conditions of the procurement of such services, which shall, where applicable, include, but not be limited to, a provision:

(e) Dividing the contract into quantifiable, measurable, and verifiable units of deliverables which ~~that~~ must be received and accepted in writing by the contract manager before payment. Each deliverable must be directly related to the scope of work and specify a performance measure. As used in this paragraph, the term "performance measure" means the required minimum level of service to be performed and criteria for evaluating the successful completion of each deliverable.

In lieu of a written agreement, the department may authorize the use of a purchase order for classes of contractual services, if the provisions of paragraphs (a)-(i) are included in the purchase order or solicitation. The purchase order must include, but need not be limited to, an adequate description of the services, the contract period, and the method of payment. In lieu of printing the provisions of paragraphs (a)-(i) in the contract document or purchase order, agencies may incorporate the requirements of paragraphs (a)-(i) by reference.

Section 10. Section 287.1312, Florida Statutes, is created to read:

287.1312 Contract manager certification.—

(1) The Department of Financial Services shall establish a certification program for contract and grant managers. A state employee may not manage a contract or grant agreement in excess of the threshold amount provided in s. 287.017 for CATEGORY FIVE without obtaining a valid certification from the Department of Financial Services under this section. The program must include training in the following areas:

(a) Procurement and the development of contracts.

(b) Development and administration of grant agreements involving federal and state financial assistance.

(c) Responsibilities of a contract manager in the management of state contracts and grant agreements.

(d) Federal and state audit and reporting requirements.

(e) Laws and rules relating to procurement and contract administration.

(f) Any other subject matter that the Chief Financial Officer determines will promote accountability in contract and grant management.

(2) The program shall provide for periodic recertification, as necessary. The Department of Financial Services shall determine course requirements, maintain information on certifications, and monitor the performance of contract and grant managers. As part of such monitoring, the department shall annually publish the results of agency manager audits and error rates related to contract and grant management on its website.

(3) The Department of Financial Services may revoke a manager's certification for incompetence or conduct inconsistent with the responsibilities of contract or grant management.

(4) The Department of Financial Services shall adopt rules to administer this section.

Section 11. Paragraph (d) of subsection (1) of section 287.133, Florida Statutes, is amended to read:

287.133 Public entity crime; denial or revocation of the right to transact business with public entities.—

(1) As used in this section:

(d) "Department" means the Department of Financial ~~Management~~ Services.

Section 12. Paragraph (h) of subsection (3) of section 255.25, Florida Statutes, is amended to read:

255.25 Approval required prior to construction or lease of buildings.—

(3)

(h) ~~The Department of Management Services may,~~ Pursuant to s. 287.042(2)~~(a)~~, the department shall procure a term contract for real estate consulting and brokerage services. A state agency may not purchase services from the contract unless the contract has been procured under s. 287.057(1) after March 1, 2007, and contains the following provisions or requirements:

1. Awarded brokers ~~must~~ maintain an office or presence in the market served. In awarding the contract, preference must be given to brokers who ~~that~~ are licensed in this state under chapter 475 and who ~~that~~ have 3 or more years of experience in the market served. The contract may be made with up to three tenant brokers in order to serve the marketplace in the north, central, and south areas of the state.

2. Each contracted tenant broker works ~~shall work~~ under the direction, supervision, and authority of the state agency, subject to the rules governing lease procurements.

3. The department provides ~~shall provide~~ training for the awarded tenant brokers concerning the rules governing the procurement of leases.

4. Tenant brokers ~~must~~ comply with all applicable provisions of s. 475.278.

5. Real estate consultants and tenant brokers are ~~shall be~~ compensated by the state agency, subject to the provisions of the term contract, and such compensation is subject to

appropriation by the Legislature. A real estate consultant or tenant broker may not receive compensation directly from a lessor for services that are rendered under the term contract. Moneys paid by a lessor to the state agency under a facility leasing arrangement are not subject to the charges imposed under s. 215.20. All terms relating to the compensation of the real estate consultant or tenant broker must ~~shall~~ be specified in the term contract and may not be supplemented or modified by the state agency using the contract.

6. The department conducts ~~shall conduct~~ periodic customer-satisfaction surveys.

7. Each state agency reports ~~shall report~~ the following information to the department:

a. The number of leases that adhere to the goal of the workspace-management initiative of 180 square feet per full-time employee ~~FTE~~.

b. The quality of space leased and the adequacy of tenant-improvement funds.

c. The timeliness of lease procurement, measured from the date of the agency's request to the finalization of the lease.

d. Whether cost-benefit analyses were performed before execution of the lease in order to ensure that the lease is in the best interest of the state.

e. The lease costs compared to market rates for similar types and classifications of space according to the official classifications of the Building Owners and Managers Association.

Section 13. Subsection (12) of section 287.012, Florida Statutes, is amended to read:

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

(12) "Exceptional purchase" means any purchase of commodities or contractual services excepted by law or rule from the requirements for competitive solicitation, including, but not limited to, purchases from a single source; purchases upon receipt of fewer ~~less~~ than two responsive bids, proposals, or replies; purchases made by an agency, after receiving approval from the department, from a contract procured, pursuant to s. 287.057(1), or by another agency; and purchases made without advertisement in the manner required under ~~by~~ s. 287.044(1)(a) ~~287.042(3)(b)~~.

Section 14. Paragraph (a) of subsection (2) of section 402.7305, Florida Statutes, is amended to read:

402.7305 Department of Children and Family Services; procurement of contractual services; contract management.—

(2) PROCUREMENT OF COMMODITIES AND CONTRACTUAL SERVICES.—

(a) Notwithstanding s. 287.057(3)(f)8. ~~287.057(3)(f)12.~~, if ~~whenever~~ the department intends to contract with a public postsecondary institution to provide a service, the department must allow all public postsecondary institutions in this state which ~~that~~ are accredited by the Southern Association of Colleges and Schools to bid on the contract. Thereafter, notwithstanding any other provision of law ~~to the contrary~~, if a public postsecondary institution intends to subcontract for any service awarded in the contract, the subcontracted service must be procured by competitive procedures.

Section 15. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the policies and

procedures of the commission, shall:

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided in s. 287.057(3)(f)8. ~~287.057(3)(f)12.~~, or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) and as otherwise limited or directed by the General Appropriations Act.

Section 16. Subsection (2) of section 946.515, Florida Statutes, is amended to read:

946.515 Use of goods and services produced in correctional work programs.—

(2) A ~~No~~ similar product or service of comparable price and quality found necessary for use by any state agency may not be purchased from any source other than the corporation if the corporation certifies that the product is manufactured by, or the service is provided by, inmates and the product or service meets the comparable performance specifications and comparable price and quality requirements as specified under s. 287.042(1)(c) ~~287.042(1)(f)~~ or as determined by an individual agency as provided in this section. The purchasing authority of ~~any~~ such state agency may make reasonable determinations of need, price, and quality with reference to products or services available from the corporation. In the event of a dispute

between the corporation and a ~~any~~ purchasing authority based upon price or quality under this section or s. 287.042(1)(c) ~~287.042(1)(f)~~, either party may request a hearing with the Department of Management Services and, if not resolved, ~~either party~~ may request a proceeding pursuant to ss. 120.569 and 120.57, which shall be referred to the Division of Administrative Hearings within 60 days after such request, to resolve any dispute under this section. A ~~No~~ party is not entitled to any appeal pursuant to s. 120.68.

Section 17. Procurement review and report.—

(1) It is the policy of this state to promote the effective procurement of goods, services, and facilities by and for the executive branch of state government through the following:

(a) Establishment of policies, procedures, and practices that require the state to procure goods, services, and facilities in a timely manner, of requisite quality, and at the lowest reasonable cost, using competitive bidding to the maximum extent possible.

(b) Improvement in the quality, efficiency, economy, and performance of organizations and personnel involved in the procurement of goods, services, and facilities by the state.

(c) Elimination of unnecessary, overlapping, or duplication of procurement and related activities, such as in contract administration.

(d) Elimination of unnecessary or redundant requirements placed on contractors or on officials in charge of state procurement procedures.

(e) Identification of gaps, omissions, or inconsistencies in state laws, rules, and directives relating to state

procurement which should be brought to the attention of the Legislature.

(f) Attainment of greater uniformity in and simplification of procurement procedures, whenever appropriate.

(g) Coordination of the procurement policies and programs of the various state agencies, whenever possible.

(h) Conformation of procurement policies and programs to other successfully established state policies and programs, whenever appropriate.

(i) Minimization of the possible disruptive effects of state procurement on particular industries, areas, or occupations.

(j) Improvement of training with respect to, and the understanding of, the laws and policies of the state relating to state procurement, not only within state government but on the part of organizations and individuals doing business with the state.

(k) Promotion of fair dealing and equitable relationships among the parties to state contracting.

(l) Promotion of economy, efficiency, and effectiveness in state procurement organizations, operations, and the uniform reporting of procurement activities by any means that the Chief Financial Officer deems beneficial and appropriate.

(m) Special consideration given to the procurement laws, policies, procedures, practices, organization, staffing, leadership, and controls of the procurement processes of the Federal Government and other states.

(n) Promotion of economy, efficiency, and effectiveness in procurement, contract management, and project management

operations.

(2) In keeping with the policies expressed in subsection (1), the Chief Financial Officer shall review and investigate:

(a) All current state laws that govern the state procurement of goods, services, and facilities;

(b) The procurement policies, rules, procedures, and practices followed by the state agencies, boards, commissions, offices, and other instrumentalities of the executive branch of state government;

(c) The organization and management processes involved in the state procurement of goods, services, and facilities before the award of a state procurement contract, during the solicitation of bids, the evaluation, and the negotiation of a contract, and subsequent to the award of the contract to determine the extent to which these organization and management processes facilitate the legislative policy set forth in this act; and

(d) Any other areas that the Chief Financial Officer deems relevant to facilitating the policies expressed in subsection (1).

(3) In order to accomplish the procurement review directed by this section, the Chief Financial Officer may:

(a) Acquire information directly from the head of any state department or agency for the purpose of conducting this review. All departments and agencies shall cooperate with the Chief Financial Officer and furnish all information requested to the extent permitted by law.

(b) Procure the services of experts and consultants.

(c) Contract with private organizations and nonprofit

institutions to carry out studies and prepare reports to facilitate the review.

(4) By December 31, 2012, the Chief Financial Officer shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report of findings and recommendations for changes in statutes, rules, policies, procedures, and organization necessary to carry out the policies set forth in this act.

Section 18. The Legislature recognizes the need to reform the purchasing cycle, from the development of a purchasing agreement to the payment for goods or services provided to the state. Therefore, chapter 287, Florida Statutes, is repealed effective July 30, 2014.

Section 19. (1) For the 2012-2013 fiscal year, the sum of $400,000 in nonrecurring funds is appropriated from the Administrative Trust Fund in the Department of Financial Services to contract for the Chief Financial Officer's review of the state's procurement process.

(2) For the 2012-2013 fiscal year, the sum of $400,000 in recurring funds from the General Revenue fund and ___ full-time equivalent positions and associated salary rate of ___ are appropriated to the Chief Financial Officer for the purpose of implementing the Chief Financial Officer's expanded contract auditing responsibilities under this act. Funds remaining unexpended or unencumbered from this appropriation as of June 30, 2013, shall revert and be reappropriated for the same purpose in the 2013-2014 fiscal year.

Section 20. This act shall take effect July 1, 2012.

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Banking and Insurance Committee - 3:15 - 5:15 412kb **Judge:**

Started: 2/2/2012 3:19:23 PM
Ends: 2/2/2012 5:14:20 PM Length: 01:54:58

3:19:35 PM Senator Richter calls meeting to order
3:20:40 PM Roll call
3:22:24 PM Tab 1 SB 1844
3:23:38 PM Tab 1 SB 1844
3:23:41 PM Tab 1 SB 1844
3:24:37 PM Roll call on SB 1844 -- passed
3:25:58 PM Tab 2 SB 1860 - Motor Vehicle Personal Injury Protection
3:26:58 PM Sen. Richter turns chair over to Vice Chair Smith
3:39:06 PM Senator Negron explains the bill
3:40:06 PM Senator Hays with question for Sen. Negron
3:43:14 PM Sen. Bennett with question to sponsor
3:44:15 PM Amendment 527256 by Sen. Richter
3:44:51 PM Sen. Richter explains the amendment
3:46:48 PM Substitute Amd. 104666 offered by Senator Gaetz--amendment withdrawn
3:53:08 PM Senator Sobel with question to Sen. Richter
3:54:09 PM Bill Newton, Executive Director, Fl Consumer Action Network speaks against amendment
3:58:14 PM Kim Driggers, Lawyer, FL Justice Assn. speaking against amendment
3:59:14 PM voice vote on Amd. 527256 -- passed
4:01:06 PM voice vote on Amd. 527256 -- passed
4:01:07 PM Amendment 220258 by Sen. Richter -- Amendment WD
4:04:37 PM Amd. 791184 by Sen. Richter--amendment withdrawn
4:07:45 PM Amd. 791184 by Sen. Richter--amendment withdrawn
4:07:49 PM Amd. to Amend. by Margolis -- both withdrawn
4:09:33 PM Michael Carlson, Executive Director,Personal Insurance Federation
4:15:27 PM Gerald Wester, American Insurance Association
4:16:27 PM Jeff Morrison D.C., Fl Chiropractice Association
4:17:58 PM Mr. Lazega, Responsive Insurance Company
4:19:02 PM Dr. Chip Smith, Chiropractor, Fl. Chiropractic Association
4:19:53 PM Cheryl Amundsen representing Put the Brakes on Accident Fraud Coalition
4:21:24 PM Janet Mabry, Consultant, FL State Massage Therapy Association
4:23:24 PM Bill Newton, FL Consumer Action Network
4:24:14 PM Motion by Senator Smith--motion for time certain vote at 4:40 -- passed
4:25:53 PM Rutledge Bradford, attorney
4:28:10 PM William Large, FL Justice Reform Institute
4:30:03 PM Mark Delegal, State Farm Mutual Automobile Ins.
4:31:03 PM Pat Mixson, Governmental Consultant
4:43:54 PM Sen. Richter moves time certain vote on bill to 4:45 -- adopted
4:44:55 PM Sen. Smith moves for CS -- adopted
4:45:06 PM Roll call on SB 1860--passed
4:45:47 PM Tab 3 SB 1862 by Sen. Negron
4:46:06 PM roll call -- passed
4:46:34 PM TAB 8 SB 1626 by Sen. Gaetz State contracting
4:46:59 PM Explanation of bill by Sen. Gaetz
4:49:08 PM Amendment 725782 - delete all amendment
4:50:08 PM Amd to Amend. Adopted
4:50:29 PM Kraig Conn, FL League of Cities
4:53:37 PM Senator Oelrich with question for Kraig Conn
4:54:38 PM Amd. 725782 - adopted
4:54:56 PM Sen. Smith moves CS for SB 1626 --
4:55:09 PM roll call -- adopted cs
4:56:48 PM Sen. Richter turns chair over to Senator Smith
4:56:49 PM TAB 4 SB 1620 relating to Insurance

4:57:37 PM Amd. 160704 -- without objection -- adopted
4:57:53 PM Amd. 929464 by Sen. Richter --without objection -- adopted
4:58:37 PM Amd. 604062 by Sen. Richter -- without objection -- adopted
4:59:09 PM Amd. 377322 -- WD
4:59:15 PM Amd. 467786 -- technical -- adopted
4:59:27 PM Amd. 464792 -- technical -- without objection -- adopted
4:59:56 PM Late filed amend. by Sen. Sobel (227828) --without objection -- adopted
5:00:43 PM Motion by Sen. Sobel -- CS -- adopted
5:01:44 PM Roll Call vote: Passed
5:02:11 PM Chair returned to Sen. Richter
5:02:31 PM Tab 6 - SB 1428 by Sen. Smith
5:02:40 PM Amd. 144930 by Sen. Smith -- without objection -- adopted
5:03:34 PM Sen. Hays moves CS -- adopted
5:03:45 PM Roll call on SB 1428 -- passed
5:04:13 PM TAB 7 SB 1814 by Sen Smith
5:04:51 PM Roll Call on SB 1814 -- passed
5:05:15 PM TAB 5 by Sen. Hays
5:05:44 PM Amd. 708624 - delete all amendment
5:06:43 PM Amd. to Amd. by Sen. Hays 935180 --without objection -- adopted
5:07:30 PM Amd. 708624 -- adopted
5:08:15 PM Matt Puckett, FL Police Benevolent Association
5:09:21 PM Lisa Henning, Director Legislative Affairs -- Fraternal Order of Police
5:10:07 PM Kraig Conn, FL League of Cities
5:11:31 PM Robert Suarez, VP, FL Professional Firefighters
5:12:24 PM Senator Negron has question for sponsor of bill
5:12:41 PM Sen. Oelrich has question for Sen. Hays
5:12:58 PM Sen. Hays recognized to close on bill
5:13:11 PM Sen. Bennett moves for CS--adopted
5:13:20 PM Roll call -- adopted
5:13:49 PM meeting adjourned.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Transportation and Economic Development Appropriations, *Chair*
Banking and Insurance
Communications, Energy, and Public Utilities
Ethics and Elections
Governmental Operations - Policy and Steering
Governmental Oversight and Accountability
Judiciary
Transportation
Ways and Means - Policy and Steering

JOINT COMMITTEE:
Legislative Budget Commission

SENATOR MIKE FASANO
President Pro Tempore
11th District

February 2, 2012

The Honorable Garrett Richter, Chairman
Senate Committee on Banking and Insurance
404 S. Monroe Street
Tallahassee, FL 32399

Dear Senator Richter,

Please excuse my absence at the Committee Meeting scheduled for today, as I am unable to attend. Thank you very much and please let me know if there is anything I can do for you.

Sincerely,

Mike

Mike Fasano
Florida State Senator, District 11

MF/gc

REPLY TO:
❒ 8217 Massachusetts Avenue, New Port Richey, Florida 34653-3111 (727) 848-5885
❒ 404 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5062

Senate's Website: *www.flsenate.gov*

JEFF ATWATER
President of the Senate

MIKE FASANO
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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SENATOR JD ALEXANDER
17th District

February 1, 2012

Senator Garrett S. Richter, Chair
Committee on Banking & Insurance
322 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Senator Richter,

I respectfully request permission to be absent from the Committee on Banking & Insurance, tomorrow, February 2, 2012. I will not be able to attend this meeting.

Thank you for your approval in this request.

Sincerely,

JD Alexander
Senator, District 17

Xc: Steve Burgess

REPLY TO:
☐ 201 Central Avenue West, Suite 115, City Hall Complex, Lake Wales, Florida 33853 (863) 679-4847
☐ 412 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5044

Senate's Website: *www.flsenate.gov*

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore