SB 144 by **Altman (CO-INTRODUCERS) Soto**; (Identical to H 1237) Payment for Services Provided by Licensed Psychologists

141354	A	S	L	RCS	BI, Benacquisto	Delete L.84 - 104.	04/09 04:53 PM

SB 814 by **Brandes**; (Compare to CS/H 0783) Registration of Branch Offices Conducting Securities Transactions

837952	D	S		RCS	BI, Montford	Delete everything after	04/09 04:53 PM

CS/SB 844 by **HP, Grimsley**; (Similar to CS/H 0939) Medicaid Fraud

SB 860 by **Galvano**; (Similar to CS/CS/H 0553) Workers' Compensation System Administration

563868	A	S		RCS	BI, Negron	Delete L.46 - 110.	04/09 04:53 PM
793356	A	S		RCS	BI, Negron	Delete L.311 - 343:	04/09 04:53 PM
496512	A	S	L	WD	BI, Ring	Delete L.202 - 214:	04/09 04:53 PM

SB 1128 by **HP**; (Compare to H 1157) Health Flex Plans

704482	D	S		RCS	BI, Hays	Delete everything after	04/09 04:53 PM

SB 1302 by **Garcia**; (Similar to CS/H 0847) Temporary Certificates for Visiting Physicians

516098	A	S		FAV	HP, Garcia	Delete L.91:	03/14 11:01 AM

SB 1498 by **Brandes**; (Compare to H 1215) Sinkhole Insurance

SB 418 by **Detert**; (Similar to CS/H 0223) Insurance

CS/SB 536 by **HP, Detert**; (Identical to CS/H 0413) Physical Therapy

SB 1006 by **Lee**; (Similar to H 0825) Tax Credits or Refunds

SB 1098 by **Richter**; (Similar to CS/CS/H 0833) General Assignments

264374	A	S		RCS	BI, Richter	Delete L.282:	04/09 04:53 PM
836278	A	S		RCS	BI, Richter	btw L.366 - 367:	04/09 04:53 PM

SB 1408 by **Richter**; (Compare to CS/H 1191) Captive Insurance

214592	D	S		RCS	BI, Richter	Delete everything after	04/09 04:53 PM

CS/SB 360 by **HP, Garcia**; (Similar to CS/H 0281) Surgical Assistants and Surgical Technologists

SPB 7152 by **BI**; Motor Vehicle Liability Insurance

SPB 7150 by **BI**; Public Records/Insurance Policies

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Simmons, Chair
Senator Clemens, Vice Chair

MEETING DATE: Tuesday, April 9, 2013
TIME: 1:30 —3:30 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Simmons, Chair; Senator Clemens, Vice Chair; Senators Benacquisto, Detert, Diaz de la Portilla, Hays, Lee, Margolis, Montford, Negron, Richter, and Ring

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointment to the office indicated.		
	Executive Director, Citizens Property Insurance Corporation		
1	Gilway, Barry J. (Ponte Vedra Beach)	Pleasure of the Board	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
2	**SB 144** Altman (Identical H 1237)	Payment for Services Provided by Licensed Psychologists; Adding licensed psychologists to the list of health care providers who are protected by a limitations period from claims for overpayment being sought by health insurers or health maintenance organizations; adding licensed psychologists to the list of health care providers who are subject to a limitations period for submitting claims to health insurers or health maintenance organizations for underpayment; adding licensed psychologists to the list of health care providers who are eligible for direct payment for medical services by a health insurer under certain circumstances, etc. HP 03/14/2013 Favorable BI 04/09/2013 Fav/CS AHS AP	Fav/CS Yeas 12 Nays 0
3	**SB 814** Brandes (Compare CS/H 783)	Registration of Branch Offices Conducting Securities Transactions; Providing that the registration of such offices is effective upon the filing of a certain form with the Office of Financial Regulation; authorizing the office to request a written supplement under certain circumstances, etc. BI 04/09/2013 Fav/CS CM JU	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 844** Health Policy / Grimsley (Similar CS/H 939)	Medicaid Fraud; Adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; deleting the requirement that the agency place payments withheld from a provider in a suspended account and revising when a provider must reimburse overpayments, etc. HP 03/07/2013 Fav/CS BI 04/09/2013 Favorable AHS AP	Favorable Yeas 12 Nays 0
5	**SB 860** Galvano (Similar CS/CS/H 553)	Workers' Compensation System Administration; Revising duties of state agencies covered by the state risk management program with respect to funding costs for employees entitled to workers' compensation benefits; revising immunity from liability standards for employers and employees using a help supply services company; revising and deleting penalties for noncompliance relating to duty of employer upon receipt of notice of injury or death; deleting a requirement that a provision that is mutually agreed upon in any collective bargaining agreement be filed with the Department of Financial Services, etc. BI 04/09/2013 Fav/CS GO JU AP	Fav/CS Yeas 11 Nays 0
6	**SB 1128** Health Policy (Compare H 1157, S 1278)	Health Flex Plans; Revising the expiration date to extend the availability of health flex plans to low-income uninsured state residents, etc. BI 04/09/2013 Fav/CS CA	Fav/CS Yeas 11 Nays 0
7	**SB 1302** Garcia (Similar CS/H 847)	Temporary Certificates for Visiting Physicians; Providing that a physician who has been invited by certain medical or surgical training programs or educational symposiums may be issued a temporary certificate for limited privileges solely to provide educational training; modifying criteria; revising the requirements for proof of medical malpractice insurance, etc. HP 03/14/2013 Fav/1 Amendment ED 04/01/2013 Favorable BI 04/09/2013 Fav/CS	Fav/CS Yeas 11 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1498** Brandes (Compare H 1215)	Sinkhole Insurance; Providing that an insurer must pay for stabilizing a structure if a sinkhole loss is verified, using a stabilization method that includes a specified type of warranty; requiring a policyholder who is paid by an insurer to stabilize a structure to repair the sinkhole; providing that a specified report to determine the presence or absence of sinkhole loss or other cause of damage is to be considered the jointly owned property of the insurer and the policyholder, etc. BI 04/09/2013 Not Considered RC	Not Considered
9	**SB 418** Detert (Similar CS/H 223)	Insurance; Authorizing the posting of specified types of insurance policies and endorsements on an insurer's Internet website in lieu of mailing or delivery to the insured if the insurer complies with certain conditions, etc. BI 04/09/2013 Favorable CM	Favorable Yeas 12 Nays 0
10	**CS/SB 536** Health Policy / Detert (Identical CS/H 413)	Physical Therapy; Authorizing physical therapists to implement physical therapy treatment plans of a specified duration which are provided by advanced registered nurse practitioners, etc. HP 03/07/2013 Fav/CS BI 04/09/2013 Favorable RC	Favorable Yeas 11 Nays 0
11	**SB 1006** Lee (Similar H 825)	Tax Credits or Refunds; Providing procedures, requirements, and calculation methodologies that allow dealers or lenders to obtain tax credits or refunds for taxes paid on worthless or uncollectable private-label credit card or dealer credit card program accounts or receivables, etc. BI 04/09/2013 Favorable AFT AP	Favorable Yeas 12 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
12	**SB 1098** Richter (Similar CS/CS/H 833)	General Assignments; Requiring an assignee's bond to be in at least a specific amount or double the liquidation value of the unencumbered and liquid assets of the estate, whichever is higher; authorizing an assignee to conduct certain discovery to determine whether to prosecute certain claims or causes of action; extending the time period for which a court may authorize an assignee to conduct the business of the assignor; providing that the Florida Rules of Civil Procedure apply to objections to claims in all pending cases beginning on a specific date, etc. JU 04/01/2013 Favorable BI 04/09/2013 Fav/CS RC	Fav/CS Yeas 12 Nays 0
13	**SB 1408** Richter (Compare CS/H 1191, CS/S 1046)	Captive Insurance; Providing that protected cell subsidiary companies are limited to only insuring or reinsuring certain risks through protected cells; requiring such company to have a minimum amount of unimpaired paid-in capital in order to be issued a license; providing that specified provisions of the insurance code apply, or do not apply, to captive insurance companies, industrial insured captive insurance companies, or protected cell subsidiary companies, etc. BI 04/09/2013 Fav/CS CM AP	Fav/CS Yeas 12 Nays 0
14	**CS/SB 360** Health Policy / Garcia (Similar CS/H 281)	Surgical Assistants and Surgical Technologists; Providing requirements for health care facilities that employ or contract with surgical assistants and surgical technologists; providing exceptions to these requirements, etc. HP 03/20/2013 Not Considered HP 04/02/2013 Fav/CS BI 04/09/2013 Favorable AHS AP	Favorable Yeas 11 Nays 0

Consideration of proposed committee bill:

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
15	**SPB 7152**	Motor Vehicle Liability Insurance; Authorizing the use of an electronic device to provide proof of insurance; increasing financial responsibility limits with respect to bodily injury or death; revising the required threshold limit for self-insurers; repealing provisions relating to the effect of law on personal injury protection policies; requiring all claims relating to personal injury to be brought in a single action; repealing provisions relating to personal injury protection benefits; requiring the insurer to notify the insured about such changes by a certain date, etc.	Temporarily Postponed
	Consideration of proposed committee bill:		
16	**SPB 7150**	Public Records/Insurance Policies; Providing a public records exemption for certain information regarding bodily injury liability insurance policies and deleting the exemption for personal injury protection policies; providing for future legislative review and repeal of the exemption for information regarding certain liability insurance policies under the Open Government Sunset Review Act; providing a statement of public necessity, etc.	Not Considered
	Other Related Meeting Documents		

1270

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Ken Detzner, Secretary of State,
do hereby certify that

Barry J. Gilway

is duly appointed Executive Director,

Citizens Property Insurance Corporation

for a term beginning on the
Sixteenth day of June, A.D., 2012,
to serve at the pleasure of the Board of Governors
and is subject to be confirmed by the Senate
during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the Twenty-Eighth day of February, A.D., 2013.

Ken Detzner

Secretary of State

DSDE 99 (3/03)

The Florida Senate

Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

Barry J. Gilway

Executive Director, Citizens Property Insurance Corporation

NOTICE OF HEARING

TO: Mr. Barry J. Gilway

YOU ARE HEREBY NOTIFIED that the Committee on Banking and Insurance of the Florida Senate will conduct a hearing on your executive appointment on Tuesday, April 09, 2013, in the Toni Jennings Committee Room, 110 Senate Office Building, commencing at 1:30 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 4th day of April, 2013

Committee on Banking and Insurance

Senator David Simmons
As Chair and by authority of the committee

cc: Members, Committee on Banking and Insurance
Office of the Sergeant at Arms

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 144
INTRODUCER:	Banking and Insurance Committee and Senators Altman and Soto
SUBJECT:	Payment for Services Provided by Licensed Psychologists
DATE:	April 10, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Favorable**
2.	Oh	Burgess	BI	**Fav/CS**
3.			AHS	
4.			AP	
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:

CS/SB 144 adds licensed psychologists to the list of health care providers who are protected by a 12-month limitation period from claims for overpayment sought by health insurers or health maintenance organizations (HMOs) and adds licensed psychologists to the list of health care providers subject to a 12-month time period for submitting claims for underpayment against health insurers or HMOs. The bill also adds licensed psychologists to the list of non-network providers who are eligible for direct payment for medical services by a health insurer.

The effective date of the bill is July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 627.6131, 641.3155 and 627.638.

II. Present Situation:

Claims of Overpayment and Underpayment

Under s. 627.6131(6), F.S. and s. 641.3155(5), F.S., respectively, health insurers and HMOs generally must submit any claim for overpayment to a health care provider within 30 months from the date of payment to the provider. The provider then has a specified time frame within which to pay the overpayment or contest the claim.[1] Under s. 627.6131(18), F.S., and s. 641.3155(16), F.S., however, a health insurer or HMO must submit a claim for overpayment against a health care provider licensed under chapters 458 (physicians), 459 (osteopaths), 460 (chiropractors), 461(podiatrists), and 466 (dental surgeons) within 12 months after the payment of the claim.

Under s. 627.6131(19), F.S., and s. 641.3155(17), F.S., respectively, a health care provider licensed under chapter 458, 459, 460, 461, and 466 must submit any claim of underpayment within 12 months after receiving payment from the insurer or HMO.

Practice of Psychology

Chapter 490, F.S., the "Psychological Services Act," governs the practice of psychology and school psychology in Florida. A person desiring to practice psychology or school psychology in Florida must be licensed by the Department of Health. "Practice of psychology" means the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[2] "Practice of school psychology" means the rendering or offering to render to an individual, a group, an organization, a government agency, or the public any of the following services-assessment, counseling, consultation, and development of programs.[3]

Psychologists who contract as preferred providers[4] or network providers with an insurer receive payment directly from the insurer for the services rendered.[5] Until legislation passed in 2009,[6] however, non-network psychologists were generally paid by the insured. After paying the psychologist, the insured then would file a claim for reimbursement with his or her insurer. In contrast, even prior to 2009, Florida law required that for non-network recognized hospitals, licensed ambulance providers, physicians, and dentists who provided services to the insured in accordance with the provisions of the insurance policy, the insurer must directly reimburse the provider if the insured specifically authorized payment of benefits directly to the provider.[7]

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[1] S. 627.6131(6)(a)(1), F.S. and s. 627.6131(6)(a)(2), F.S.
[2] S. 490.003(4), F.S.
[3] S. 490.003(5), F.S.
[4] S. 627.6471(1)(b), F.S. It defines preferred provider as, "any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment…"
[5] S. 627.638(3), F.S.
[6] Ch. 2009-124, L.O.F.
[7] S. 627.638(2), F.S.

Assignment of Benefits for Health Insurance Claims

Prior to the 2009 Legislative Session, s. 627.638(2), F.S., required that, when specifically authorized by the insured, a health insurer was required to make direct payment to any recognized hospital, licensed ambulance provider, physician, or dentist, unless "otherwise provided in the insurance contract." The pre-2009 law further provided that an insurance contract had to provide for the option of direct payment to a licensed hospital, licensed ambulance provider, physician, or dentist for emergency services or emergency medical transportation services.

In 2009, the Legislature amended s. 627.638(2), F.S., to remove the qualifying language: "otherwise provided in the insurance contract." The amending language also added "other person[s] who provided the services in accordance with the provisions of the policy" to the list of specified professionals who are entitled to direct payment if specifically authorized by the insured.[8] The effect of this legislation was to require that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers, physicians, dentists, and other persons who provide services in accordance with the provisions of the insurance policy.

Due to concerns that these provisions might lead to increased costs to the state's group health plan as a result of providers leaving the network,[9] language was included in ch. 2009-124, L.O.F., providing for the amendments to be automatically repealed on July 1, 2012, and the language in s. 627.638(2), F.S., to revert to the language that existed on June 30, 2009, if the Office of Program Policy Analysis and Government Accountability (OPPAGA) made certain findings in a study to be published on or before March 1, 2012. The language was to be repealed if the OPPAGA found that:

- The amendments caused the third-party administrator of the state's group health plan to suffer a net loss of physicians from its preferred provider plan network; and
- As a direct result, the state's group health plan incurred an increase in costs.[10]

In January 2012, the OPPAGA issued the requisite report, and summary statements about the report are as follows:

- Statutory changes made by the 2009 Legislature that require the state group health plan's third party administrator to directly pay non-network providers for services did not result in a loss of network physicians. Since December 2009, the number of physicians participating in Blue Cross and Blue Shield of Florida's (BCBS) preferred provider network for the state group has increased by 12.5 percent. In addition, while the number and amount of non-network physician and other profession claims has increased slightly since 2009, the proportion of these claims to overall physician and other profession claims for the state group

[8] Ch. 2009-124, L.O.F.
[9] Generally, an insurer will permit the policyholder to make an assignment of benefits for direct payment to providers with whom the insurer has contracted to be part of a network such as a Preferred Provider Organization (PPO). The ability to receive direct payment from the insurer is one of the reasons health care providers agree to become part of a preferred provider network, often in exchange for a reduced payment from the insurer.
[10] S. 2, ch. 2009-124, L.O.F.

has remained at about 2 percent. Moreover, the discount rate BCBS negotiates with network providers for the state group has remained relatively unchanged.
- Overall costs for state group health participants have increased; per enrollee per month costs increased from $479 in Fiscal Year 2008-09 to $541 in Fiscal Year 2010-2011. However, these increased costs cannot be directly linked to the 2009 law because many factors contribute to rising health care costs.[11]

III. Effect of Proposed Changes:

Section 1 amends s. 627.6131, F.S., relating to overpayment or underpayment of claims by health insurers to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 2 amends s. 641.3155, F.S., relating to overpayment or underpayment of claims by an HMO to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 3 amends s. 627.638(2), F.S., to include non-network psychologists in the specified list of provider:

- To whom an insurer must make direct payment, if the insured specifically authorizes the payment of benefits directly to a recognized hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with the policy;
- For which an insurance contract may not prohibit the direct payment of benefits; and
- For which an insurer must provide a claim form with an option for direct payment of benefits.

Section 4 provides an effective date of July 1, 2013.

[11] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, pages 2 and 4, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf(last viewed April 4, 2013) (on file with Health Innovation Subcommittee staff).

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:

Psychologists will have a quicker turnaround time for receiving claims for overpayment from insurers or HMOs.

Health insurance carriers and HMOs will incur some administrative costs for revising health insurance forms to allow for the selection of a psychologist for direct payment for services rendered for hospital and emergency medical services.

C. Government Sector Impact:

The Office of Insurance Regulation anticipates an increase in health form review as a result of the additional category of providers eligible for direct payment on any health insurance form, but the increased form review can absorbed within current resources.[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 627.638(2), F.S., requires that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers, physicians, dentists, and "other person[s] who provide services" in accordance with the provisions of the insurance policy. The term "other person who provided the services" appears to be a catch-all provision that covers all health care providers, including psychologists.

[12] Florida Office of Insurance Regulation, Legislative Affairs, *HB 1237*, March 13, 2013, page 3 (on file with Health Innovation Subcommittee staff).

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 April 9, 2013
The original bill was drafted with two alternative versions of s. 627.638(2), F.S., because when it was initially drafted, the proper version of s. 627.638, F.S., was contingent upon the findings of the OPPAGA report required by chapter 2009-124, L.O.F. Because the report has been published, the language of s. 627.638(2), F.S., is no longer contingent. Accordingly, the CS removed alternative language for s. 627.638(2), F.S., which was in the original bill.

B. Amendments:

None.


141354

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment (with directory amendment)

Delete lines 84 - 104.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete lines 62 - 67
and insert:
Section 3. Subsection (2) of section 627.638, Florida Statutes, is amended to read:

By Senator Altman

16-00203-13 2013144__

A bill to be entitled

An act relating to payment for services provided by licensed psychologists; amending ss. 627.6131 and 641.3155, F.S.; adding licensed psychologists to the list of health care providers who are protected by a limitations period from claims for overpayment being sought by health insurers or health maintenance organizations; adding licensed psychologists to the list of health care providers who are subject to a limitations period for submitting claims to health insurers or health maintenance organizations for underpayment; amending s. 627.638, F.S.; adding licensed psychologists to the list of health care providers who are eligible for direct payment for medical services by a health insurer under certain circumstances; making technical and grammatical changes; providing an effective date.

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

Section 1. Subsections (18) and (19) of section 627.6131, Florida Statutes, are amended to read:

627.6131 Payment of claims.—

(18) Notwithstanding the 30-month period provided in subsection (6), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment of the claim. A claim for overpayment is ~~may~~ not ~~be~~ permitted

16-00203-13 2013144__

~~beyond~~ 12 months after the health insurer's payment of a claim, except that claims for overpayment may be sought after ~~beyond~~ that time from providers convicted of fraud pursuant to s. 817.234.

(19) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health insurer's payment of a claim.

Section 2. Subsections (16) and (17) of section 641.3155, Florida Statutes, are amended to read:

641.3155 Prompt payment of claims.—

(16) Notwithstanding the 30-month period provided in subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought after ~~beyond~~ that time from providers convicted of fraud pursuant to s. 817.234.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the health maintenance organization within 12 months after the health maintenance

organization's payment of the claim. A claim for underpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health maintenance organization's payment of a claim.

Section 3. Contingent upon the Office of Program Policy Analysis and Government Accountability not presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida, and the text of subsection (2) of section 627.638, Florida Statutes, not reverting to that in existence on June 30, 2009, that subsection is amended to read:

627.638 Direct payment for hospital, medical services.—

(2) For ~~Whenever, in~~ any health insurance claim form, if an insured specifically authorizes payment of benefits directly to a ~~any~~ recognized hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with ~~the provisions of~~ the policy, the insurer shall make such payment to the designated provider of such services. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with ~~the provisions of~~ the policy for care provided. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

Section 4. Contingent upon the Office of Program Policy Analysis and Government Accountability presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida, and the text of subsection (2) of section 627.638, Florida Statutes,

reverting to that in existence on June 30, 2009, that subsection is amended to read:

627.638 Direct payment for hospital, medical services.—

(2) For ~~Whenever, in~~ any health insurance claim form, if an insured specifically authorizes payment of benefits directly to a ~~any~~ recognized hospital, licensed ambulance provider, physician, ~~or~~ dentist, or psychologist, the insurer shall make such payment to the designated provider of such services, unless otherwise provided in the insurance contract. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, ~~or~~ dentist, or psychologist for care provided pursuant to s. 395.1041 or part III of chapter 401. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

Section 5. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4-8-13
Meeting Date

Topic Payment for Services Provided by Licenced Psychologists

Bill Number SB 144 *(if applicable)*

Name Connie Galietti

Amendment Barcode _____ *(if applicable)*

Job Title Executive Director

Address 408 office Plaza Dr.
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-656-2222

E-mail Connie@flapsych.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Psychological 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

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 814
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Registration of Branch Offices Conducting Securities Transactions
DATE:	April 9, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Fav/CS**
2.			CM	
3.			JU	
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:

CS/SB 814 requires each securities dealer and investment adviser to submit to the Office of Financial Regulation (OFR) a notice filing of each branch office from which the dealer or adviser conducts business. The notice filing is effective upon OFR receipt of the filing and a filing fee of $100. As under current law, it is unlawful for a securities dealers or investment adviser to conduct business form a branch office that has not filed with the OFR, the only difference being the bill's requirement of a notice filing. A key difference between the notice filing process of the bill and registration of a branch office, as required under current law, is that registration of a branch office is only effective after the OFR has reviewed the registration and approved it.

The OFR must summarily suspend a branch office notice filing if the notice filer fails to provide to the OFR all information required as part of a filing within 30 days after the OFR makes a written request for such information. The summary suspension is effective until the notice filer submits the requested information to the OFR, and pays an administrative fine. A notice filing must be revoked by the OFR if the notice filer fails to provide all requested information within 90 days, and may be revoked if the notice filer makes a payment to the OFR via check or electronic funds transmission (EFT) that is dishonored. All fees become state revenue except for

an administrative fine under s. 517.221(3), F.S., for failure to timely provide information requested by the OFR, until the Securities Guaranty Fund satisfies the statutory limits. Fees are not returnable if a branch office notice filing is withdrawn.

The effective date of the bill is October 1, 2013.

This bill creates the following sections of the Florida Statutes: 517.1202

This bill substantially amends the following sections of the Florida Statutes: 517.12, 517.1205, 517.121, 517.161, 517.1611, and 517.211.

II. Present Situation:

Regulation of Securities

The securities industry is subject to both federal and state law and to the state and federal regulatory agencies that implement statutory law. The primary federal regulator is the Securities and Exchange Commission (SEC), which oversees the key participants in the securities industry such as securities exchanges, securities brokers and dealers, investment advisors, and mutual funds.[1] The SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing, and protecting against fraud.

The Office of Financial Regulation, through the Division of Securities, regulates the sale of securities in, to, or from Florida by firms, branch offices and individuals affiliated with these firms to determine compliance with Florida law. A securities dealer or investment adviser is prohibited from conducting business from a branch office in Florida unless the branch office is registered with the Office of Financial Regulation (OFR).[2] A "branch office" is "any location in this state of a dealer or investment adviser at which one or more associated persons regularly conduct the business of rendering investment advice or effecting any transactions in, or inducing or attempting to induce the purchase or sale of, any security."[3] It also includes any location that is held out as a place where such actions occur is also a branch office.

The Financial Industry Regulatory Authority (FINRA), an independent, not-for-profit organization, also is an important regulatory body.[4] FINRA performs a number of functions, including registering and educating securities industry participants. FINRA operates the Central Registration Depository and the Investment Adviser Registration Depository, which are central databases for registering, reporting, and disclosing information within the securities industry.

[1] See http://www.sec.gov/about/whatwedo.shtml (Accessed April 6, 2013).
[2] S. 517.12(5), F.S.
[3] S. 517.021(4), F.S.
[4] See http://www.finra.org/AboutFINRA/P125239 (Accessed April 6, 2013).

Registration of Securities Branch Offices

To register a branch office, the securities dealer must file the required form[5] and pay an application fee.[6] The branch office must resubmit an updated form upon any changes in personnel or any material fact that render the registration inaccurate.[7] Branch office registration is effective upon OFR approval, after a review that the registration complies with Florida law. According to representatives of the Office of Financial Regulation, since July 1, 2012, the average amount of time for the OFR to process and approve a broker-dealer branch office is 5 days upon receipt of registration and 6 days for an investment adviser branch office. Approximately 15 percent of branch office registration applications, however, contain deficiencies that delay the approval date and operation of the branch location.

III. Effect of Proposed Changes:

Section 2 creates s. 517.1202, F.S., to provide notice filing requirements for branch offices. The "notice filing" of a branch office is effective upon its receipt of the filing and required fee by the OFR. Each dealer and each investment adviser must pay a filing fee of $100 for each branch office in the state.[8] A notice filing consists of a form the Financial Services Commission may prescribe by rule. As under current law, it is unlawful for a securities dealers or investment adviser to conduct business from a branch office that has not filed with the OFR, the only difference being the bill's requirement of a notice filing. A key difference between the notice filing process of the bill and registration under current law is that registration of a branch office is only effective after the OFR has reviewed the registration and approved it.

Each notice filing expires on December 31 of the year the filing was made, unless the filing is renewed on or before that date. A branch office notice is renewed when the dealer or securities adviser furnishes to the OFR information required by the FSC or OFR, a $100 renewal fee, and any amount due and owing the office pursuant to an agreement with the OFR. If a branch office registration expires, the dealer or investment adviser may request reinstatement on or before the January 31 following expiration by providing requested information, the $100 renewal fee, and a $100 late fee. A branch office reinstatement is effective retroactive to January 1 of that year. The bill authorizes the FSC to require, by rule, a dealer or investment adviser to file amendments to a branch office notice filing.

The OFR must summarily suspend a branch office notice filing if the notice filer fails to provide to the OFR all information required as part of a filing within 30 days after the OFR makes a written request for such information. The summary suspension is effective until the notice filer submits the requested information to the OFR, pays an administrative fine pursuant to s. 517.221(3), F.S.,[9] and a final order is entered. For purposes of emergency suspension of licenses failure to provide all information required pursuant to branch office notice filing is grounds for the emergency suspension of a license under s. 120.60(6), F.S., because such failure

[5] The OFR requires the filing of Form BR, Uniform Branch Office Registration Form (Adopted 2005) as authorized under s. 617.12(15)(a)1., F.S.
[6] R. 69W-600.004(3), F.A.C.
[7] R. 69W-600.004(3)(c), F.A.C.
[8] The notice filing fee is the same as the registration fee under current law.
[9] An administrative fine may not exceed $10,000.

constitutes an immediate and serious danger to the public health, safety, and welfare. A notice filing must be revoked by the OFR if the notice filer fails to provide all requested information within 90 days. The OFR may revoke a branch office notice if the notice filer makes a payment to the OFR via check or electronic funds transmission (EFT) that is dishonored. A dealer or investment adviser may terminate a branch office notice filing by filing a notice of termination with the OFR, the effective date of which is either as specified in the notice of termination or upon receipt by the OFR if the notice does not specify an effective date.

All fees become state revenue except for an administrative fine under s. 517.221(3), F.S., for failure to timely provide information requested by the OFR, until the Securities Guaranty Fund satisfies the statutory limits. Fees are not returnable if a branch office notice filing is withdrawn.

Sections 1, 3, 4, 5, 6 and 7 make conforming changes to ss. 517.12, 517.1205, 517.121, 517.161(1), 517.1611, and 517.211, F.S., related to the bill requiring branch office notice filings instead of registration.

Section 8 provides an effective date of October 1, 2013.

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:

Proponents of the bill from the securities industry assert delays in the current registration process sometimes adversely affects dealers and investment advisors. A dealer or investment advisor may not conduct business from a branch office that is not properly registered with the OFR. Accordingly, unanticipated delays in the registration process may require the suspension of business activities until the OFR approves the branch registration.

Representatives from the Office of Financial Regulation state that the OFR no longer has enforcement concerns related to improper filings because the revisions to the bill contained in the CS authorize remedies for branch office filings that are inaccurate or do not comply with state law.

C. Government Sector Impact:

None. The computer programming changing to the OFR's online registration and licensing system can be accomplished without additional resources.

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 April 9, 2013:

- Strikes the entire original bill.
- Requires each securities dealer and investment adviser to submit to the Office of Financial Regulation (OFR) a notice filing of each branch office from which the dealer or adviser conducts business.
- Makes a notice filing effective upon OFR receipt of the filing and a filing fee of $100.
- Requires the OFR to summarily suspend a branch office notice filing if the notice filer fails to provide to the OFR all information required as part of a filing within 30 days after the OFR makes a written request for such information.
- Allows reinstatement of form filings under certain circumstances.
- Requires revocation of a form filing by the OFR if the notice filer fails to provide all requested information within 90 days.
- Provides that all branch office filing fees become state revenue except for an administrative fine under s. 517.221(3), F.S., for failure to timely provide information requested by the OFR, until the Securities Guaranty Fund satisfies the statutory limits.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsections (5), (6), (10), (11), (12), (14), and (15) of section 517.12, Florida Statutes, are amended to read:

517.12 Registration of dealers, associated persons, and investment advisers~~, and branch offices~~.—

(5) No dealer or investment adviser shall conduct business from a branch office within this state unless the branch office is notice-filed with the office pursuant to s. 517.1202


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~~registered with the office pursuant to the provisions of this section~~.

(6) A dealer, associated person, or investment adviser, ~~or branch office,~~ in order to obtain registration, must file with the office a written application, on a form which the commission may by rule prescribe. The commission may establish, by rule, procedures for depositing fees and filing documents by electronic means provided such procedures provide the office with the information and data required by this section. Each dealer or investment adviser must also file an irrevocable written consent to service of civil process similar to that provided for in s. 517.101. The application shall contain such information as the commission or office may require concerning such matters as:

(a) The name of the applicant and the address of its principal office and each office in this state.

(b) The applicant’s form and place of organization; and, if the applicant is a corporation, a copy of its articles of incorporation and amendments to the articles of incorporation or, if a partnership, a copy of the partnership agreement.

(c) The applicant’s proposed method of doing business and financial condition and history, including a certified financial statement showing all assets and all liabilities, including contingent liabilities of the applicant as of a date not more than 90 days prior to the filing of the application.

(d) The names and addresses of all associated persons of the applicant to be employed in this state and the offices to which they will be assigned.

(10) An applicant for registration shall pay an assessment


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fee of $200, in the case of a dealer or investment adviser, or $50, in the case of an associated person. An associated person may be assessed an additional fee to cover the cost for the fingerprint cards to be processed by the office. Such fee shall be determined by rule of the commission. ~~Each dealer and each investment adviser shall pay an assessment fee of $100 for each office in this state.~~ Such fees become the revenue of the state, except for those assessments provided for under s. 517.131(1) until such time as the Securities Guaranty Fund satisfies the statutory limits, and are not returnable in the event that registration is withdrawn or not granted.

(11) If the office finds that the applicant is of good repute and character and has complied with the provisions of this chapter and the rules made pursuant hereto, it shall register the applicant. The registration of each dealer, investment adviser, ~~branch office,~~ and associated person expires on December 31 of the year the registration became effective unless the registrant has renewed his or her registration on or before that date. ~~The commission may establish by rule procedures for renewing the registration of a branch office through the Central Registration Depository.~~ Registration may be renewed by furnishing such information as the commission may require, together with payment of the fee required in subsection (10) for dealers, investment advisers, or associated persons~~, or branch offices~~ and the payment of any amount lawfully due and owing to the office pursuant to any order of the office or pursuant to any agreement with the office. Any dealer, investment adviser, or associated person~~, or branch office registrant~~ who has not renewed a registration by the time the

current registration expires may request reinstatement of such registration by filing with the office, on or before January 31 of the year following the year of expiration, such information as may be required by the commission, together with payment of the fee required in subsection (10) for dealers, investment advisers, or associated persons~~, or branch office~~ and a late fee equal to the amount of such fee. Any reinstatement of registration granted by the office during the month of January shall be deemed effective retroactive to January 1 of that year.

(12)(a) The office may issue a license to a dealer, investment adviser, or associated person~~, or branch office~~ to evidence registration under this chapter. The office may require the return to the office of any license it may issue prior to issuing a new license.

(b) Every dealer, investment adviser, or federal covered adviser shall promptly file with the office, as prescribed by rules adopted by the commission, notice as to the termination of employment of any associated person registered for such dealer or investment adviser in this state and shall also furnish the reason or reasons for such termination.

(c) Each dealer or investment adviser shall designate in writing to, and register with, the office a manager for each office the dealer or investment adviser has in this state.

(14) Every dealer or~~,~~ investment adviser~~, or branch office~~ registered or required to be registered, or branch office notice-filed or required to be notice-filed, with the office shall keep records of all currency transactions in excess of $10,000 and shall file reports, as prescribed under the financial recordkeeping regulations in 31 C.F.R. part 103, with


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the office when transactions occur in or from this state. All reports required by this subsection to be filed with the office shall be confidential and exempt from s. 119.07(1) except that any law enforcement agency or the Department of Revenue shall have access to, and shall be authorized to inspect and copy, such reports.

(15)(a) In order to facilitate uniformity and streamline procedures for persons who are subject to registration or notification in multiple jurisdictions, the commission may adopt by rule uniform forms that have been approved by the Securities and Exchange Commission, and any subsequent amendments to such forms, if the forms are substantially consistent with the provisions of this chapter. Uniform forms that the commission may adopt to administer this section include, but are not limited to:

1. Form BR, Uniform Branch Office Registration Form, adopted October 2005.

2. Form U4, Uniform Application for Securities Industry Registration or Transfer, adopted October 2005.

3. Form U5, Uniform Termination Notice for Securities Industry Registration, adopted October 2005.

4. Form ADV, Uniform Application for Investment Adviser Registration, adopted October 2003.

5. Form ADV-W, Notice of Withdrawal from Registration as an Investment Adviser, adopted October 2003.

6. Form BD, Uniform Application for Broker-Dealer Registration, adopted July 1999.

7. Form BDW, Uniform Request for Broker-Dealer Withdrawal, adopted August 1999.


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(b) In lieu of filing with the office the applications specified in subsection (6), the fees required by subsection (10), the renewals required by subsection (11), and the termination notices required by subsection (12), the commission may by rule establish procedures for the deposit of such fees and documents with the Central Registration Depository or the Investment Adviser Registration Depository of the Financial Industry Regulatory Authority, as developed under contract with the North American Securities Administrators Association, Inc.

Section 2. Section 517.1202, Florida Statutes, is created to read:

517.1202 Notice filing requirements for branch offices.—

(1) It is unlawful for a dealer or investment adviser to conduct business from a branch office in this state unless the dealer or investment adviser has made a branch office notice filing with the office. A notice filing under this section consists of a form that the commission may prescribe by rule. The commission may establish, by rule, procedures for the deposit of fees and filing of documents by electronic means if the procedures provide the office with the information and data required by this section.

(2) A notice filing shall be effective upon receipt by the office of the form and filing fee. Each dealer and each investment adviser shall pay a filing fee of $100 for each branch office in this state.

(3) A notice filing shall expire on December 31 of the year in which the filing became effective unless the dealer or investment adviser has renewed the filing on or before that date. A dealer or investment adviser may renew a branch office

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notice filing by furnishing to the office such information as the commission or office may require, together with a renewal fee of $100 and the payment of any amount due and owing the office pursuant to any agreement with the office. Any dealer or investment adviser who has not renewed a branch office notice filing by the time a current notice filing expires may request reinstatement of such notice filing by filing with the office, on or before January 31 of the year following the year the notice filing expires, such information as the commission or office may require, together with the filing fee of $100 and a late fee equal to $100. Any reinstatement of a branch office notice filing granted by the office during the month of January shall be deemed effective retroactive to January 1 of that year.

(4) A branch office notice filing under this section shall be summarily suspended by the office if the notice filer fails to provide to the office, within 30 days after a written request by the office, all of the information required by this section and the rules adopted under this section. The summary suspension shall be in effect for the branch office until such time as the notice filer submits the requested information to the office, pays a fine as prescribed by s. 517.221(3), and a final order is entered. At such time, the suspension shall be lifted. For purposes of s. 120.60(6), failure to provide all information required by this section and the underlying rules constitutes immediate and serious danger to the public health, safety, and welfare. If the notice filer fails to provide all of the requested information within a period of 90 days, the notice filing shall be revoked by the office.

(5) Notification under this section may be revoked by the


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office if the notice filer makes payment to the office for a branch office notice filing with a check or electronic transmission of funds which is dishonored by the notice filer's financial institution.

(6) The commission may require, by rule, a dealer or investment adviser who has made a branch office notice filing pursuant to this section to file amendments with the office.

(7) A branch office notice filing may be terminated by filing notice of such termination with the office. Unless another date is specified by the dealer or investment adviser, such notice shall be effective upon its receipt by the office.

(8) All fees collected under this section become the revenue of the state, except for those assessments provided for under s. 517.131(1) until such time as the Securities Guaranty Fund satisfies the statutory limits, and are not returnable in the event that a branch office notice filing is withdrawn.

Section 3. Section 517.1205, Florida Statutes, is amended to read:

517.1205 Registration of associated persons specific as to securities dealer, investment adviser, or federal covered adviser identified at time of registration approval.—Inasmuch as this chapter is intended to protect investors in securities offerings and other investment transactions regulated by that chapter, its provisions are to be construed to require full and fair disclosure of all, but only, those matters material to the investor's evaluation of the offering or other transaction. It should, furthermore, be construed to impose the standards provided by law on all those seeking to participate in the state's securities industry through registration as a securities

dealer, investment adviser, or associated person. To this end, it is declared to be the intent of the Legislature that the registration of associated persons required by law is specific to the securities dealer, investment adviser, or federal covered adviser identified at the time such registration is approved. Notwithstanding any interpretation of law to the contrary, the historical practice of the Department of Banking and Finance, reflected in its rules, that requires a new application for registration from a previously registered associated person when that person seeks to be associated with a new securities dealer or investment adviser is hereby ratified and approved as consistent with legislative intent. It is, finally, declared to be the intent of the Legislature that while approval of an application for registration of a securities dealer, investment adviser, or associated person~~, or branch office~~ requires a finding of the applicant's good repute and character, such finding is precluded by a determination that the applicant may be denied registration on grounds provided by law.

Section 4. Subsections (2) and (3) of section 517.121, Florida Statutes, are amended to read:

517.121 Books and records requirements; examinations.—

(2) The office shall, at intermittent periods, examine the affairs and books and records of each registered dealer, investment adviser, ~~branch office, or~~ associated person, or branch office notice-filed with the office, or require such records and reports to be submitted to it as required by rule of the commission, to determine compliance with this act.

(3) Registration under s. 517.12 or notification under s. 517.1202 may be summarily suspended by the office pursuant to s.


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120.60(6) if the registrant or notice-filed branch office fails to promptly provide to the office, after a written request, any of the records required by this section and the rules adopted under this section. The suspension may be rescinded if the registrant or notice-filed branch office submits the requested records to the office. For purposes of s. 120.60(6), failure to provide substantially all of such records constitutes immediate and serious danger to the public health, safety, and welfare.

Section 5. Paragraphs (j) and (n) of subsection (1) of section 517.161, Florida Statutes, are amended to read:

517.161 Revocation, denial, or suspension of registration of dealer, investment adviser, or associated person~~, or branch office~~.—

(1) Registration under s. 517.12 may be denied or any registration granted may be revoked, restricted, or suspended by the office if the office determines that such applicant or registrant; any member, principal, or director of the applicant or registrant or any person having a similar status or performing similar functions; or any person directly or indirectly controlling the applicant or registrant:

(j) Has been convicted of, or has entered a plea of guilty or nolo contendere to, regardless of whether adjudication was withheld, a crime against the laws of this state or any other state or of the United States or of any other country or government which relates to registration as a dealer, investment adviser, issuer of securities, or associated person~~, or branch office~~; which relates to the application for such registration; or which involves moral turpitude or fraudulent or dishonest dealing;

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(n) Made payment to the office for a registration ~~or notice filing~~ with a check or electronic transmission of funds that is dishonored by the applicant's or~~,~~ registrant's~~, or notice filer's~~ financial institution.

Section 6. Paragraph (b) of subsection (2) of section 517.1611, Florida Statutes, is amended to read:

517.1611 Guidelines.—

(2) The commission shall adopt by rule disqualifying periods pursuant to which an applicant will be disqualified from eligibility for registration based upon criminal convictions, pleas of nolo contendere, or pleas of guilt, regardless of whether adjudication was withheld, by the applicant; any partner, member, officer, or director of the applicant or any person having a similar status or performing similar functions; or any person directly or indirectly controlling the applicant.

(b) The disqualifying periods shall be related to crimes involving registration as a dealer, investment adviser, issuer of securities, or associated person~~, or branch office~~ or the application for such registration or involving moral turpitude or fraudulent or dishonest dealing.

Section 7. Subsection (1) of section 517.211, Florida Statutes, is amended to read:

517.211 Remedies available in cases of unlawful sale.—

(1) Every sale made in violation of either s. 517.07 or s. 517.12(1), (4), (5), (9), (11), (13), (16), or (18) may be rescinded at the election of the purchaser, except a sale made in violation of the provisions of s. 517.1202(3) ~~517.12(11)~~ relating to a renewal of a branch office notification ~~registration~~ shall not be subject to this section, and a sale

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made in violation of the provisions of s. 517.12(13) relating to filing a change of address amendment shall not be subject to this section. Each person making the sale and every director, officer, partner, or agent of or for the seller, if the director, officer, partner, or agent has personally participated or aided in making the sale, is jointly and severally liable to the purchaser in an action for rescission, if the purchaser still owns the security, or for damages, if the purchaser has sold the security. No purchaser otherwise entitled will have the benefit of this subsection who has refused or failed, within 30 days of receipt, to accept an offer made in writing by the seller, if the purchaser has not sold the security, to take back the security in question and to refund the full amount paid by the purchaser or, if the purchaser has sold the security, to pay the purchaser an amount equal to the difference between the amount paid for the security and the amount received by the purchaser on the sale of the security, together, in either case, with interest on the full amount paid for the security by the purchaser at the legal rate, pursuant to s. 55.03, for the period from the date of payment by the purchaser to the date of repayment, less the amount of any income received by the purchaser on the security.

Section 8. This act shall take effect October 1, 2013.

================ 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


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An act relating to branch offices conducting securities transactions; amending s. 517.12, F.S.; providing for a branch office notice filing with the Office of Financial Regulation in lieu of registration; creating s. 517.1202, F.S.; prohibiting a securities dealer or investment advisor from conducting business from a branch office unless a specified notice has been filed with the office; providing requirements and procedures with respect to notice filing for branch offices; authorizing the Financial Services Commission to adopt rules relating to such notice filings; providing a fee for a branch office notice filing; providing for expiration, renewal, suspension, revocation, and termination of branch office notice filings under specified circumstances; providing applicability and construction with respect to fees collected for branch office notice filings; amending ss. 517.1205, 517.121, 517.161, 517.1611, and 517.211, F.S.; conforming provisions to changes made by the act with respect to requiring branch office notice filings with the Office of Financial Regulation in lieu of registration; providing an effective date.

By Senator Brandes

22-00572A-13 2013814__

A bill to be entitled

An act relating to the registration of branch offices conducting securities transactions; amending s. 517.12, F.S.; providing that the registration of such offices is effective upon the filing of a certain form with the Office of Financial Regulation; authorizing the office to request a written supplement under certain circumstances; providing an effective date.

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

Section 1. Subsections (5) and (6) of section 517.12, Florida Statutes, are amended to read:

517.12 Registration of dealers, associated persons, investment advisers, and branch offices.—

(5) No dealer or investment adviser shall conduct business from a branch office within this state unless the branch office is registered with the office pursuant to ~~the provisions of~~ this section. Registration is effective upon the filing of Securities and Exchange Commission Form BR, Uniform Branch Office Registration Form, with the office through the Central Registration Depository maintained by the Financial Industry Regulatory Authority. The office may request the filing of a written supplement if the office finds that the Form BR is incomplete or inaccurate. The form of the supplement shall be determined by the commission.

(6) In order to obtain registration, a dealer, associated person, or investment adviser~~, or branch office, in order to obtain registration,~~ must file with the office a written application, on a form that ~~which~~ the commission may by rule prescribe. The commission may establish, by rule, procedures for depositing fees and filing documents by electronic means if ~~provided~~ such procedures provide the office with the information and data required by this section. Each dealer or investment adviser shall ~~must~~ also file an irrevocable written consent to service of civil process similar to that provided under ~~for in~~ s. 517.101. The application must ~~shall~~ contain such information as the commission or office may require concerning such matters as:

(a) The name of the applicant and the address of its principal office and each office in this state.

(b) The applicant's form and place of organization; and, if the applicant is a corporation, a copy of its articles of incorporation and amendments to the articles of incorporation or, if a partnership, a copy of the partnership agreement.

(c) The applicant's proposed method of doing business and financial condition and history, including a certified financial statement showing all assets and all liabilities, including the contingent liabilities of the applicant up to ~~as of a date not more than~~ 90 days before ~~prior to~~ the filing of the application.

(d) The names and addresses of all associated persons of the applicant to be employed in this state and the offices to which they will be assigned.

Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

_____
Meeting Date

Topic Branch Office Registration

Bill Number 814 *(if applicable)*

Name Sean Stafford

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address _____
Street

Phone 850-727-5000

_____
City *State* *Zip*

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing Financial Services Institute

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)

4/9
Meeting Date

Topic Registration of Branch Office - Securities

Bill Number 814 *(if applicable)*

Name French Brown

Amendment Barcode 837952 *(if applicable)*

Job Title Director of Legislative Affairs

Address 200 E. Gaines St.
Street

Phone 850-410-9544

Tallahassee FL 32399
City *State* *Zip*

E-mail French.Brown@gmail.com

Speaking: [X] For [ ] Against [ ] Information

Representing Office of Financial Regulation

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

APPEARANCE RECORD

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

4/9/13
Meeting Date

Topic Branch office Registration

Bill Number 814 *(if applicable)*

Name Warren Husband

Amendment Barcode *(if applicable)*

Job Title

Address PO Box 10909
Street

Phone 850 2059000

Tallahassee FL 32302
City *State* *Zip*

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing Securities Industry & Financial Markets 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.

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 Committee on Banking and Insurance

BILL:	CS/SB 844
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Medicaid Fraud
DATE:	April 5, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.	Johnson	Burgess	BI	**Favorable**
3.			AHS	
4.			AP	
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:

CS/SB 844 modifies existing statutory provisions relating to fraud and abuse, provider controls and accountability in the Medicaid program. These modifications include the following:

- Increasing the records retention time for all medical and Medicaid related records from 5 to 6 years for Medicaid providers;
- Requiring Medicaid providers to report a change in any principal of the provider to the Agency for Health Care Administration (AHCA) in writing no later than 30 days after the change occurs;
- Defining "administrative fines" for purposes of liability for payment of such fines in the event of a change of ownership;
- Authorizing, rather than requiring, the AHCA to perform onsite inspections of the service location of a provider applying for a provider agreement to determine that provider's ability to provide services in compliance with the Medicaid program and regulations;
- Providing a definition for principals of a provider with a controlling interest for hospitals and nursing homes, for purposes of conducting criminal background checks;
- Removing certain exceptions to background screenings requirements for Medicaid providers;

- Expanding the list of offenses for which the AHCA may terminate the participation of a Medicaid provider in the Medicaid program;
- Requiring the AHCA to impose the sanction of termination for cause against a provider that voluntarily relinquishes their Medicaid provider number under certain circumstances;
- Requiring that when the AHCA determines that an overpayment has been made that the AHCA must base their determination solely on the information available before the issuance of an audit report and upon contemporaneous records;
- Clarifying when the interest rate accrues on provider payments paid by the AHCA that had been withheld on a suspicion of fraud or abuse, if it is determined that there was no fraud or abuse;
- Removing the 30 day time provision related to records that may be presented to contest an overpayment or sanction;
- Requiring overpayments or fines be paid to the AHCA within 30 days after the date of the final order and are not subject to further appeal; and,
- Clarifying the scope of immunity from civil liability for persons who report fraudulent acts or suspected fraudulent acts.

CS/SB 844 is not expected to have any fiscal impact on state government as the AHCA reports that any workload increases can be absorbed within existing resources.

The act takes effect July 1, 2013.

This bill substantially amends, the following sections of the Florida Statutes: 409.907, 409.913, and 409.920.

II. Present Situation:

Health Care Fraud

In 2009, the Legislature passed CS/CS/CS/SB 1986, a comprehensive bill designed to address systematic health care fraud in Florida. That bill increased the Medicaid program's authority to address fraud, particularly as it relates to home health services; health care facility and health care practitioner standards to keep fraudulent actors from obtaining a health care license in Florida. The bill also created disincentives to commit Medicaid fraud and created additional criminal felonies for committing health care fraud.

With more than 3 years experience with the implementation of CS/CS/CS/SB 1986, some changes have been identified which would enhance Florida's efforts to prevent additional health care fraud and abuse in Florida's Medicaid program. This bill addresses some of the gaps in enforcement authority, strengthens the reporting requirements by Medicaid providers and Medicaid managed care organizations and defines the consequences for failure to comply with the requirements.

Regulatory Authority of AHCA

The AHCA regulates hospitals and nursing homes under the authority of chapters 395 and 400, F.S., respectively, along with dozens of other health care entities such as clinical laboratories, ambulatory surgical centers, hospices, and home health agencies. General licensing provisions for these providers are found in part II of ch. 408, F.S. The Bureau for Health Facility Regulation conducts the activities that certify and license the entities under the AHCA's jurisdiction.

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with costs of nursing facility care and other medical expenses. The AHCA is designated as the single state agency responsible for Medicaid. Medicaid serves approximately 3.3 million people in Florida. The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Medicaid reimburses health care providers that have a provider agreement with the AHCA only for covered goods and services and only for individuals who are eligible for Medicaid assistance from Medicaid. Section 409.907, F.S., establishes requirements for Medicaid provider agreements, which include among other things, background screening requirements, notification requirements for change of ownership of a Medicaid provider, authority for AHCA site visits of provider service locations, and surety bond requirements.

Under s. 409.913, F.S., the AHCA is responsible for overseeing the integrity of the Medicaid program, to ensure the fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.

Sections 409,920, 409.9201, 409.9203, and 409.9205, F.S., contain provisions relating specifically to Medicaid fraud. A person who provides the State with information about fraud or suspected fraud by a Medicaid provider, including a managed care organization, is immune from civil liability for providing that information unless the person knew the information was false or acted with reckless disregard for the truth or falsity of the information.[1]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed care medical assistance program. The law directs the AHCA to begin implementation of the long term managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. The State received federal approval of this program on February 1, 2013.[2] Although the AHCA has

[1] *See* s. 409.920(8), F.S.
[2] Agency for Health Care Administration, *February 1, 2013 Waiver Approval Letter*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (Last visited on March 4, 2013).

received conditional approval,[3] the AHCA is still awaiting final approval of the managed medical assistance program whose full implementation is anticipated by October 1, 2014.

Background Screening

Chapter 435, F.S., establishes standards for background screening for employment. Section 435.03, F.S., sets standards for Level 1 background screening. Level 1 background screening includes, but is not limited to, employment history checks and statewide criminal correspondence checks through the Department of Law Enforcement and a check of the Dru Sjodin National Sex Offender Public Website, and may include local criminal records checks through local law enforcement agencies.

Level 2 background screenings includes, but is not limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history records checks through the Federal Bureau of Investigation. They may also include local criminal records checks through local law enforcement agencies. Section 435.04(2), F.S., lists the offenses that will disqualify an applicant from employment.

Section 408.809, F.S., establishes background screening requirements and procedures for entities licensed by the AHCA. The AHCA must conduct Level 2 background screening for specified individuals. Each person subject to this section is subject to Level 2 background screening every 5 years. This section of law also specifies additional disqualifying offenses beyond those included in s. 435.04(2), F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 409.907, F.S., relating to Medicaid provider agreements, to require Medicaid providers to retain all medical and Medicaid-related records for 6 years, rather than the current statutory retention period of 5 years, consistent with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules.[4]

The bill requires a Medicaid provider to report in writing any change of any principal of the provider whose ownership interest is equal to 5 percent or more to the AHCA no later than 30 days after the change occurs. The bill specifies who is included in the term "principal." The definition of a controlling interest is already defined by statute under s. 408.803(7), F.S., and includes:

- The applicant or licensee;
- A person or entity that serves as an officer of, is on the board or has a 5 percent or greater ownership interest in the applicant or licensee; or,

[3] Agency for Health Care Administration, *February 20, 2013 Agreement in Principle Letter*, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (Last visited on March 4, 2013).

[4] *See* 45 CFR 164.316(b)(2). Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=be9877c2440a17a8ebe3b02b0948a06a&rgn=div8&view=text&node=45:1.0.1.3.79.3.27.8&idno=45> (Last visited on March 1, 2013).

- A person or entity that serves as an officer of, is on the board, or has a 5 percent or greater management interest in the management company or other entity, related or unrelated, that the applicant or licensee contracts with to manage the provider.
- The term does not include a voluntary board member.

The bill clarifies the statutory provisions relating to the liability of Medicaid providers in a change of ownership for outstanding overpayments, administrative fines, and any other moneys owed to the AHCA. The bill defines "administrative fines" to include any amount identified in any notice of a monetary penalty or fine that has been issued by the AHCA or any other regulatory or licensing agency that governs the provider.

The requirement for the AHCA to conduct random onsite inspections of Medicaid providers' service locations within 60 days after receipt of a fully complete new provider's application and prior to making the first payment to the provider for Medicaid services is amended to authorize, rather than require, the AHCA to perform onsite inspections. The inspection would be conducted prior to the AHCA entering into a Medicaid provider agreement with the provider and would be used to determine the applicant's ability to provide services in compliance with the Medicaid program and professional regulations. The law currently only requires the AHCA to determine the applicant's ability to provide the services for which they will seek Medicaid payment.

The bill also removes an exception to the current onsite-inspection requirement for a provider or program that is licensed by the AHCA, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Families, since the selection of providers for onsite inspections is no longer a random selection, but is left up to the discretion of the AHCA under the bill.

The bill amends existing surety bond requirements for certain Medicaid providers. The bill clarifies that the additional bond required by the AHCA, if a provider's billing during the first year exceeds the bond amount, need not exceed $50,000 for certain providers. A provider could have a bond greater than $50,000, if the provider so elected.

The bill amends the requirements for a criminal history record check of each Medicaid provider, or each principal of the provider, to remove an exemption from such checks for hospitals, nursing homes, hospices, and assisted living facilities. The bill specifies that for hospitals and nursing homes the principals of the provider are those who meet the definition of a controlling interest in s. 408.803, F.S., under the general licensing provisions for health care facilities regulated by the AHCA.

The bill removes the provision that proof of compliance with Level 2 background screening under ch. 435, F.S., conducted within 12 months before the date the Medicaid provider application is submitted to the AHCA satisfies the requirements for a criminal history background check. This conforms to screening provisions in ch. 435, F.S., and ch. 408, F.S.

Section 2 amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program. The bill amends the length of time that Medicaid providers are required to retain their records to be consistent with federal law. Medicaid providers are required to retain medical, professional,

financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 years, rather than the current statutory retention period of 5 years.

The bill amends subsection (13) of s. 409.913, F.S., to remove a requirement that the AHCA *immediately* terminate participation of a Medicaid provider that has been convicted of certain offenses. In order to terminate a provider immediately, the AHCA must show an immediate harm to the public health, which is not always possible. The AHCA still must terminate a Medicaid provider from participation in the Medicaid program, unless the AHCA determines that the provider did not participate or acquiesce in the offense. The change will resolve a current conflict with the Administrative Procedures Act.[5]

The AHCA may seek civil remedies or impose administrative sanctions if a provider *has been convicted* of any of the following offenses.

- A criminal offense under federal law or the law of any state relating to the practice of the provider's profession.
- An offense listed in s. 409.907(10), F.S., relating to factors the AHCA may consider when reviewing an application for a Medicaid provider agreement, which includes:
  - Making a false representation or omission of any material fact in making an application for a provider agreement;
  - Exclusion, suspension, termination, or involuntary withdrawal from participation in any Medicaid program or other governmental or private health care or health insurance program;
  - Being convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;
  - Being convicted of a criminal offense under federal or state law related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;
  - Being convicted of a criminal offense under federal or state law related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
  - Being convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
  - Being convicted of a criminal offense under federal or state law punishable by imprisonment of 1 year or more which involves moral turpitude;
  - Being convicted in connection with the interference or obstruction of any investigation into any criminal offense listed above;
  - Violation of federal or state laws, rules, or regulations governing any Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, if they have been sanctioned accordingly;
  - Violation of the standards or conditions relating to professional licensure or certification or the quality of services provided; or
  - Failure to pay fines and overpayments under the Medicaid program.

[5] *See* s. 120.569(2)(n), F.S. which requires that "if any agency head finds that an immediate danger to the public health , safety, or welfare requires an immediate final order, it shall recite with particularity the facts underlying such finding in the final order, which shall be appealable or enjoinable from the date ordered."

- An offense listed in s. 408.809(4), F.S., relating to background screening of licensees, which includes the following offenses or any similar offense of another jurisdiction:
  - Any authorizing statutes, if the offense was a felony;
  - Chapter 408, F.S., if the offense was a felony;
  - Section 409.920, F.S., relating to Medicaid provider fraud;
  - Section 409.9201, F.S., relating to Medicaid fraud;
  - Section 741.28, F.S., relating to domestic violence;
  - Section 817.034, F.S., relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems;
  - Section 817.234, F.S., relating to false and fraudulent insurance claims;
  - Section 817.505, F.S., relating to patient brokering;
  - Section 817.568, F.S., relating to criminal use of personal identification information;
  - Section 817.60, F.S., relating to obtaining a credit card through fraudulent means;
  - Section 817.61, F.S., relating to fraudulent use of credit cards, if the offense was a felony;
  - Section 831.01, F.S., relating to forgery;
  - Section 831.02, F.S., relating to uttering forged instruments;
  - Section 831.07, F.S., relating to forging bank bills, checks, drafts, or promissory notes;
  - Section 831.09, F.S., relating to uttering forged bank bills, checks, drafts, or promissory notes;
  - Section 831.30, F.S., relating to fraud in obtaining medicinal drugs; or
  - Section 831.31, F.S., relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- An offense listed in s. 435.04(2), F.S., relating to employee background screening, which includes the following offenses or any similar offense of another jurisdiction:
  - Section 393.135, F.S., relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct;
  - Section 394.4593, F.S., relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct;
  - Section 415.111, F.S., relating to adult abuse, neglect, or exploitation of aged persons or disabled adults;
  - Section 782.04, F.S., relating to murder;
  - Section 782.07, F.S., relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child;
  - Section 782.071, F.S., relating to vehicular homicide;
  - Section 782.09, F.S., relating to killing of an unborn quick child by injury to the mother;
  - Chapter 784, F.S., relating to assault, battery, and culpable negligence, if the offense was a felony;
  - Section 784.011, F.S., relating to assault, if the victim of the offense was a minor;
  - Section 784.03, F.S., relating to battery, if the victim of the offense was a minor;
  - Section 787.01, F.S., relating to kidnapping;
  - Section 787.02, F.S., relating to false imprisonment;
  - Section 787.025, F.S., relating to luring or enticing a child;
  - Section 787.04(2), F.S., relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings;

- Section 787.04(3), F.S., relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person;
- Section 790.115(1), F.S., relating to exhibiting firearms or weapons within 1,000 feet of a school;
- Section 790.115(2)(b), F.S., relating to possessing an electric weapon or device, destructive device, or other weapon on school property;
- Section 794.011, F.S., relating to sexual battery;
- Former s. 794.041, F.S., relating to prohibited acts of persons in familial or custodial authority;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Chapter 796, F.S., relating to prostitution;
- Section 798.02, F.S., relating to lewd and lascivious behavior;
- Chapter 800, F.S., relating to lewdness and indecent exposure;
- Section 806.01, F.S., relating to arson;
- Section 810.02, F.S., relating to burglary;
- Section 810.14, F.S., relating to voyeurism, if the offense is a felony;
- Section 810.145, F.S., relating to video voyeurism, if the offense is a felony;
- Chapter 812, F.S., relating to theft, robbery, and related crimes, if the offense is a felony;
- Section 817.563, F.S., relating to fraudulent sale of controlled substances, only if the offense was a felony;
- Section 825.102, F.S., relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult;
- Section 825.103, F.S., relating to exploitation of an elderly person or disabled adult, if the offense was a felony;
- Section 826.04, F.S., relating to incest;
- Section 827.03, F.S., relating to child abuse, aggravated child abuse, or neglect of a child;
- Section 827.04, F.S., relating to contributing to the delinquency or dependency of a child;
- Former s. 827.05, F.S., relating to negligent treatment of children;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 843.01, F.S., relating to resisting arrest with violence;
- Section 843.025, F.S., relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication;
- Section 843.12, F.S., relating to aiding in an escape;
- Section 843.13, F.S., relating to aiding in the escape of juvenile inmates in correctional institutions;
- Chapter 847, F.S., relating to obscene literature;
- Section 874.05(1), F.S., relating to encouraging or recruiting another to join a criminal gang;
- Chapter 893, F.S., relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor;
- Section 916.1075, F.S., relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct;
- Section 944.35(3), F.S., relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm;

- Section 944.40, F.S., relating to escape;
- Section 944.46, F.S., relating to harboring, concealing, or aiding an escaped prisoner;
- Section 944.47, F.S., relating to introduction of contraband into a correctional facility;
- Section 985.701, F.S., relating to sexual misconduct in juvenile justice programs; or
- Section 985.711, F.S., relating to contraband introduced into detention facilities.

The bill amends subsection (15) of s. 409.913, F.S., relating to noncriminal actions of Medicaid providers for which the AHCA may impose sanctions, to include the act of *authorizing* certain services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality, or *authorizing* certain requests and reports that contain materially false or incorrect information. The bill also adds that the AHCA may sanction a provider if the provider is charged by information or indictment with any offense referenced in subsection (13). (See above for a listing of the offenses.) The AHCA may impose sanctions under this subsection if the provider or certain persons affiliated with the provider participated or acquiesced in the proscribed activity.

Subsection (16) of s. 409.913, F.S., relating to sanctions the AHCA may impose for the acts listed in subsection (15), is amended to state that, if a Medicaid provider voluntarily relinquishes its Medicaid provider number after receiving notice of an audit or investigation for which the sanction of suspension or termination will be imposed, the AHCA must impose the sanction of termination for cause against the provider. Currently, if a Medicaid provider receives notification that it is going to be suspended or terminated, the provider is able to voluntarily terminate their contract. By doing this, a provider has the ability to avoid sanctions of suspension or termination, which would affect the ability of the provider to reenter the program in the future. Existing language in this subsection gives the Secretary of the AHCA the authority to make a determination that imposition of a sanction is not in the best interest of the Medicaid program, in which case a sanction may not be imposed.

The bill amends subsection (21) of s. 409.913, F.S., to specify that when the AHCA is making a determination that an overpayment has occurred, the determination must be based solely upon information available to it before it issues the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

Subsection (22) is amended to specify that a provider may not present records to contest a sanction that is not based upon contemporaneous records and, if requested during the audit process, were provided to the AHCA or its agent upon request. Also, all documentation to be offered as evidence in an administrative hearing on an administrative sanction (in addition to Medicaid overpayments) must be exchanged by all parties at least 14 days before the administrative hearing or excluded from consideration.

Subsection (25) of s. 409.913, F.S., is amended to clarify when interest accrues on provider payments withheld by the AHCA based on suspected fraud or criminal activity, if it is determined that there was no fraud or that a crime did not occur. Interest on provider payments to be paid after an investigation will accrue at 10 percent a year beginning after the 14th day. A provision relating to the placement of funds in a suspended account held by the AHCA is deleted and a payment deadline of 14 days to the provider is removed. Payment arrangements for

overpayments and fines owed to the AHCA must be made within 30 days after the date of the final order and are not subject to further appeal.

The bill amends subsection (28) of s. 409.913, F.S., to make Leon County the venue for all Medicaid program integrity cases, not just overpayment cases. However, the AHCA has discretion concerning venue.

Subsection (30) of s. 409.913, F.S., is amended to require the AHCA to terminate a provider's participation in the Medicaid program if the provider fails to pay a fine within 30 days after the date of the final order imposing the fine. The time within which a provider must reimburse an overpayment is reduced from 35 to 30 days after the date of the final order. Subsection (31) is amended to include fines, as well as overpayments, that are due upon the issuance of a final order at the conclusion of a requested administrative hearing.

Section 3 amends s. 409.920, F.S., relating to Medicaid provider fraud, to clarify that the existing immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts is for civil liability for libel, slander, or any other relevant tort. The bill defines "fraudulent acts" for purposes of immunity from civil liability to include actual or suspected fraud and abuse, insurance fraud, licensure fraud or public insurance fraud; including any fraud-related matters that a provider or health plan is required to report to the AHCA or a law enforcement agency. The immunity from civil liability extends to reports conveyed to the AHCA in any manner, including forums, and incorporates all discussions subsequent to the report and subsequent inquiries from the AHCA, unless the person reporting acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information.

Section 4 provides an effective date of July 1, 2013.

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:

Entities and individual health care providers under Medicaid currently exempt from background checks will be required to complete the same requirements as other Medicaid providers.

The total fee for a Level 2 background screening is $64.50 ($24.00 for the state portion, $16.50 for the national portion, and $24.00 for retention). There is an additional fee of $11-$16 for electronic screening, depending on the provider. The cost of the screening is borne by the individual provider.[6]

C. Government Sector Impact:

The agency reports no fiscal impact. Medicaid contract management believes there may be an increase in initial screenings of registered treating providers, but does not believe this will have a fiscal impact on the agency.[7]

The Department of Children and Families did not report any fiscal impact.

To the extent that a governmental entity has providers or is a provider that are not currently required to provide a completed background checks prior to Medicaid provider enrollment and not otherwise exempt, additional costs may be incurred to comply with this requirement.

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 Health Policy on March 7, 2013
CS/SB 844 deletes a separate requirement for Level 2 background checks of providers under contract with Medicaid managed care networks. All Medicaid providers participating under fee for service must still comply with this requirement. The CS removed a provision relating to the coordination of anti-fraud report reviews between the Department of Financial Services and the AHCA. The CS does not include the provision allowing the AHCA to consider information from non-Medicaid providers during an investigation. The CS also removed the 30-day provision related to records that may be presented to contest an overpayment or sanction. Interest payments to the providers that

[6] Agency for Health Care Administration, *supra*, note 1 at 6.
[7] Agency for Health Care Administration, *supra*, note 1 at 5.

had been withheld are reinstated and the timeframe for when interest is applied is clarified.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Grimsley

588-02020-13 2013844c1

A bill to be entitled

An act relating to Medicaid fraud; amending s. 409.907, F.S.; increasing the number of years a provider must keep records; adding an additional provision relating to a change in principal that must be included in a Medicaid provider agreement with the Agency for Health Care Administration; adding definitions for "administrative fines" and "outstanding overpayment"; revising provisions relating to the agency's onsite inspection responsibilities; revising provisions relating to who is subject to background screening; amending s. 409.913, F.S.; increasing the number of years a provider must keep records; revising provisions specifying grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; providing a limitation on the information the agency may consider when making a determination of overpayment; specifying the type of records a provider must present to contest an overpayment; deleting the requirement that the agency place payments withheld from a provider in a suspended account and revising when a provider must reimburse overpayments; revising venue requirements; adding provisions relating to the payment of fines; amending s. 409.920, F.S.; clarifying provisions relating to immunity from liability for persons who provide information about Medicaid fraud; providing an effective date.

588-02020-13 2013844c1

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

Section 1. Paragraph (c) of subsection (3) of section 409.907, Florida Statutes, is amended and paragraph (k) is added to that subsection, and subsections (6), (7), and (8) of that section are amended to read:

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

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(c) Retain all medical and Medicaid-related records for 6 ~~a period of 5~~ years to satisfy all necessary inquiries by the agency.

(k) Report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider, to the agency in writing within 30 days after the change occurs. For a hospital licensed under chapter 395 or a nursing home

licensed under part II of chapter 400, a principal of the provider is one who meets the definition of a controlling interest under s. 408.803.

(6) A Medicaid provider agreement may be revoked, at the option of the agency, due to ~~as the result of~~ a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) If there is ~~In the event of~~ a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change ~~of ownership~~. ~~In addition to the continuing liability of the transferor,~~ The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. ~~For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of the change of ownership.~~ In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

(b) At least 60 days before the anticipated date of the

change of ownership, the transferor must ~~shall~~ notify the agency of the intended change ~~of ownership~~ and the transferee must ~~shall~~ submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are ~~shall be~~ jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change ~~of ownership~~. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change ~~of ownership~~.

(c) As used in this subsection, the term:

1. "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs

the provider.

2. "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

(7) ~~The agency may require,~~ As a condition of participating in the Medicaid program and before entering into the provider agreement, the agency may require ~~that~~ the provider to submit information, in an initial and any required renewal applications, concerning the professional, business, and personal background of the provider and permit an onsite inspection of the provider's service location by agency staff or other personnel designated by the agency to perform this function. Before entering into a provider agreement, the agency may ~~shall~~ perform an ~~a random~~ onsite inspection~~, within 60 days after receipt of a fully complete new provider's application,~~ of the provider's service location ~~prior to making its first payment to the provider for Medicaid services~~ to determine the applicant's ability to provide the services in compliance with the Medicaid program and professional regulations ~~that the applicant is proposing to provide for Medicaid reimbursement~~. ~~The agency is not required to perform an onsite inspection of a provider or program that is licensed by the agency, that provides services under waiver programs for home and community-based services, or that is licensed as a medical foster home by the Department of Children and Family Services.~~ As a continuing condition of participation in the Medicaid program, a provider must ~~shall~~ immediately notify the agency of any current or pending bankruptcy filing. Before entering into the provider agreement, or as a condition of continuing participation in the

Medicaid program, the agency may also require that Medicaid providers reimbursed on a fee-for-services basis or fee schedule basis that ~~which~~ is not cost-based, post a surety bond not to exceed $50,000 or the total amount billed by the provider to the program during the current or most recent calendar year, whichever is greater. For new providers, the amount of the surety bond shall be determined by the agency based on the provider's estimate of its first year's billing. If the provider's billing during the first year exceeds the bond amount, the agency may require the provider to acquire an additional bond equal to the actual billing level of the provider. A provider's bond need ~~shall~~ not exceed $50,000 if a physician or group of physicians licensed under chapter 458, chapter 459, or chapter 460 has a 50 percent or greater ownership interest in the provider or if the provider is an assisted living facility licensed under chapter 429. The bonds permitted by this section are in addition to the bonds referenced in s. 400.179(2)(d). If the provider is a corporation, partnership, association, or other entity, the agency may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater, and any treating provider who participates in or intends to participate in Medicaid through the entity. The information must include:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws or~~,~~ rules~~, or regulations~~ of this state or of any other state or the Federal Government; any prior violation of the laws or~~,~~ rules~~, or regulations~~ relating to the Medicare program; any prior violation of the rules ~~or regulations~~ of any other public or private insurer; and any prior violation of the laws or~~,~~ rules~~, or regulations~~ of any regulatory body of this or any other state.

(c) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(d) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Medicaid program.

(8)~~(a)~~ Each provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, seeking to participate in the Medicaid program must submit a complete set of his or her fingerprints to the agency for the purpose of conducting a criminal history record check. Principals of the provider include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider. However, for a hospital licensed under chapter 395 or a nursing home licensed under chapter 400, principals of the provider are those who meet the

definition of a controlling interest under s. 408.803. A director of a not-for-profit corporation or organization is not a principal for purposes of a background investigation ~~as~~ required by this section if the director: serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration from the not-for-profit corporation or organization for his or her service on the board of directors, has no financial interest in the not-for-profit corporation or organization, and has no family members with a financial interest in the not-for-profit corporation or organization; and if the director submits an affidavit, under penalty of perjury, to this effect to the agency and the not-for-profit corporation or organization submits an affidavit, under penalty of perjury, to this effect to the agency as part of the corporation's or organization's Medicaid provider agreement application. Notwithstanding the above, the agency may require a background check for any person reasonably suspected by the agency to have been convicted of a crime.

(a) This subsection does not apply to:

~~1. A hospital licensed under chapter 395;~~

~~2. A nursing home licensed under chapter 400;~~

~~3. A hospice licensed under chapter 400;~~

~~4. An assisted living facility licensed under chapter 429;~~

1.~~5.~~ A unit of local government, except that requirements of this subsection apply to nongovernmental providers and entities contracting with the local government to provide Medicaid services. The actual cost of the state and national

criminal history record checks must be borne by the nongovernmental provider or entity; or

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

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

~~(c) Proof of compliance with the requirements of level 2 screening under chapter 435 conducted within 12 months before the date the Medicaid provider application is submitted to the agency fulfills the requirements of this subsection.~~

Section 2. Subsections (9), (13), (15), (16), (21), (22), (25), (28), (30) and (31) of section 409.913, Florida Statutes, are amended to read:

409.913 Oversight of the integrity of the Medicaid program.—The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The

report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating

conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year.

(9) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for 6 ~~a period of 5~~ years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider must keep ~~is responsible for furnishing to the agency, and keeping~~ the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

(13) The agency shall ~~immediately~~ terminate participation of a Medicaid provider in the Medicaid program and may seek civil remedies or impose other administrative sanctions against a Medicaid provider, if the provider or any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under s. 409.907(10), s.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

408.809(4), or s. 435.04(2) ~~has been:~~

~~(a) Convicted of a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services;~~

~~(b) Convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession; or~~

~~(c) Found by a court of competent jurisdiction to have neglected or physically abused a patient in connection with the delivery of health care goods or services~~. If the agency determines that the ~~a~~ provider did not participate or acquiesce in the ~~an~~ offense ~~specified in paragraph (a), paragraph (b), or paragraph (c),~~ termination will not be imposed. If the agency effects a termination under this subsection, the agency shall take final agency action ~~issue an immediate final order pursuant to s. 120.569(2)(n)~~.

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

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

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

(c) The provider has not furnished or has failed to make

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available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

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

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

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

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

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

(i) The provider or an authorized representative of the provider, or a person who has ordered, authorized, or prescribed

the goods or services, has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;

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

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

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

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

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

the provider's billings to the Medicaid program;

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

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

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

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

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

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

(b) Termination for a specific period of time ranging ~~of~~ from more than 1 year to 20 years. Termination precludes ~~shall preclude~~ participation in the Medicaid program, which includes any action that results in a claim for payment to the Medicaid program for ~~as a result of~~ furnishing, supervising a person who

is furnishing, or causing a person to furnish goods or services.

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

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

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

(f) Imposition of liens against provider assets, including, but not limited to, financial assets and real property, not to

exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable.

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

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

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

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

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

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

available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records.

(22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony~~,~~ ~~either~~ on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. Notwithstanding the applicable rules of discovery, all documentation to ~~that will~~ be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or ~~must~~ be excluded from consideration.

(25)(a) The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a

withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination ~~with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days~~. Amounts not paid within 14 days accrue interest at the rate of 10 percent a year, beginning after the 14th day.

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

(c) Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of final determination of the overpayment by the agency, and payment arrangements must be made within 30 days after the date of the final order, which is not subject to further appeal ~~at the conclusion of legal proceedings~~. ~~A provider who does not enter into or adhere to an agreed upon repayment schedule may be terminated by the agency for nonpayment or partial payment.~~

(d) The agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the moneys owed by all means allowable by law, including, but not limited to, notifying

any fiscal intermediary of Medicare benefits that the state has a superior right of payment. Upon receipt of such written notification, the Medicare fiscal intermediary shall remit to the state the sum claimed.

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

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

(30) The agency shall terminate a provider's participation in the Medicaid program if the provider fails to reimburse an overpayment or pay an agency-imposed fine that has been determined by final order, not subject to further appeal, within 30 ~~35~~ days after the date of the final order, unless the provider and the agency have entered into a repayment agreement.

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

Section 3. Subsection (8) of section 409.920, Florida Statutes, is amended to read:

409.920 Medicaid provider fraud.—

(8) A person who provides the state, any state agency, any of the state's political subdivisions, or any agency of the state's political subdivisions with information about fraud or suspected fraudulent acts ~~fraud~~ by a Medicaid provider, including a managed care organization, is immune from civil liability for libel, slander, or any other relevant tort for providing ~~the~~ information about fraud or suspected fraudulent acts, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. For purposes of this subsection, the term "fraudulent acts" includes actual or suspected fraud and abuse, insurance fraud, licensure fraud, or public assistance fraud, including any fraud-related matters that a provider or health plan is required to report to the agency or a law enforcement agency.

Section 4. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1
Meeting Date

Topic _____ Bill Number 944 *(if applicable)*

Name Leslie Dughi Amendment Barcode _____ *(if applicable)*

Job Title _____

Address _____ Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Representing Associated Industries

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

APPEARANCE RECORD

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

4/9/13
Meeting Date

Topic Medicaid Fraud

Bill Number 844 *(if applicable)*

Name LAURA LENHART

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address _____ *Street*

Phone _____

_____ *City* *State* *Zip*

E-mail _____

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

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 860
INTRODUCER:	Banking and Insurance Committee and Senator Galvano
SUBJECT:	Workers' Compensation System Administration
DATE:	April 9, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.			GO	
3.			JU	
4.			AP	
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:

CS/SB 860 amends provisions relating to the administration of Florida's workers' compensation system. The bill provides the following changes:

- Provides that stop-work orders and penalties assessed against a limited liability company (LLC) continue in force against successor companies of the LLC to the same extent (and under the same conditions) that they remain in force against successor companies of corporations, partnerships, and sole proprietorships.
- Eliminates the DFS certification requirement for workers' compensation health care providers.
- Provides additional time for health care providers, carriers, and employers to file medical reimbursement disputes with the DFS, for carriers to respond to petitions, and for the DFS to issue a written determination.
- Eliminates the following requirements: (1) that the DFS approve the advance payment of workers' compensation benefits in certain circumstances; (2) that carriers submit reemployment status reports to the DFS for review; (3) that a vocational evaluation always be conducted prior to the DFS authorizing training and education for an injured employee; and (4) that the DFS serve as custodian of certain collective bargaining agreements.

This bill substantially amends the following sections of the Florida Statutes: 284.44, 440.02, 440.05, 440.102, 440.107, 440.11, 440.13, 440.15, 440.185, 440.20, 440.211, 440.385, and 440.491.

II. Present Situation:

Chapter 440, F.S., is Florida's workers' compensation law. The Division of Workers' Compensation within the Department of Financial Services is responsible for administering ch. 440, F.S. Generally, employers/carriers are required to provide medical and indemnity benefits to a worker who is injured due to an accident arising out of and during the course of employment. For such compensable injuries, an employer/carrier is responsible for providing medical treatment, which includes, but is not limited to, medically necessary care and treatment.

Coverage Requirements

Whether an employer is required to have workers' compensation insurance depends upon the employer's industry and the number of employees. Employers may secure coverage by purchasing a workers' compensation insurance policy or qualifying as a self-insurer.[1]
In Florida, any contractor or subcontractor who engages in construction in the state must secure and maintain workers' compensation insurance.[2] No more than three officers of a corporation or members of a limited liability company, who are engaged in the construction industry, may elect to be exempt from this requirement, if certain conditions are met.[3] Corporate officers and members of a non-construction LLC who own at least 10 percent of a LLC can elect to be exempt from workers' compensation coverage requirements. Individuals who make such election are not considered employees for premium calculation purposes, and are not entitled to workers compensation benefits if they suffer a workplace injury.

In 2012, the Legislature enacted changes[4] relating to the application process for the workers' compensation exemption. Electronic filing of exemption applications was required. As a result, applicants no longer needed to provide their social security number, but are required to include their date of birth, Florida driver license number, or Florida identification card number[5] on their application. An unintended consequence of the amended data reporting requirements was to preclude out-of-state corporate officers, who would otherwise have been eligible for an exemption, from filing an electronic application, as they could not possess a Florida driver license or Florida identification card. Current practice at the DFS is to accept paper applications from out-of-state applicants and issue exemptions when all other eligibility criteria are met.

If an employer fails to comply with coverage requirements, the DFS must issue a stop-work order (SWO) within 72 hours of knowledge of non-compliance. SWOs require the employer to

[1] Sections 440.38, F.S.
[2] Sections 440.10 and 440.38, F.S.
[3] Section 440.02, F.S.
[4] Chapter 2012-213, L.O.F.
[5] The Florida Department of Highway Safety and Motor Vehicles issues non-driver identification cards to State residents above 12 years of age who do not have a valid ID card, driver license or instruction permit from the State or any other jurisdiction. See http://www.dmv.com/fl/florida/apply-id-card.

cease business operations and remain in effect until the DFS issues an Order Releasing the Stop-Work Order. Additionally, employers are assessed penalties equal to 1.5 times what the employer would have paid in workers' compensation premiums for all periods of non-compliance during the preceding 3-year period or $1,000, whichever is greater.[6] SWOs are issued for the following violations: failure to obtain workers' compensation insurance; materially understating or concealing payroll; materially misrepresenting or concealing employee duties to avoid paying the proper premium; materially concealing information pertinent to the calculation of an experience modification factor; and failure to produce business records in a timely manner.

To prevent a person or business from circumventing these sanctions, s. 440.107, F.S., provides that a SWO and associated penalties continue in force against a successor entity of a corporation, partnership, or sole proprietorship if certain conditions are met. The application of the sanctions would apply to the successor entity if it were engaged in the same or equivalent trade or activity as the business that was issued the SWO and has one or more of the same principals or officers as the business that was issued the SWO. The workers' compensation law is silent as to whether SWOs and associated penalties continue in force against successor entities of limited liability companies (LLCs).[7]

Certified Health Care Providers and Reimbursement Disputes

A health care provider rendering medical treatment and care to an injured employee must be certified pursuant to Rule 69L-29.002, F.A.C., by the DFS or deemed certified, pursuant to s. 440.13(1)(d), F.S., as a provider within a managed care organization licensed through the Agency for Health Care Administration. Section 440.13(1) (d), F.S., provides that a "certified health care provider" is a provider approved to receive reimbursement through the Florida workers' compensation system. A certified provider may be a physician, a licensed practitioner, or a facility approved by the DFS, or a provider who has entered an agreement with a licensed managed care organization to provide treatment to injured employees. Generally, a certified health care provider must receive authorization from the insurer before providing treatment.

The DFS is responsible for resolving medical reimbursement disputes between health care providers and insurance carriers. Providers have 30 days from receipt of notice of disallowance or adjustment of payment from a carrier to file a dispute petition with the DFS. Carriers have 10 days from receipt of the provider's petition to submit to the DFS all documentation substantiating the carrier's disallowance or adjustment; otherwise, they waive all objections to the petition. The DFS has 60 days from receipt of all documentation to issue a written determination. The provider or the workers' compensation carrier, or either party's designated representative, may contest the DFS's determination by filing a request for an administrative hearing under ch. 120, F.S.

Workers' Compensation Indemnity Benefits

Workers' compensation indemnity (monetary) benefits are payable to employees who miss at least 8 days of work due to a covered (compensable) injury. However, indemnity benefits are

[6] Section 440.107, F.S.
[7] Section 440.107(7)(b), F.S.

payable retroactively from the first day of disability (to include compensation for the first 7 days missed) to employees who miss more than 21 days of work due to a compensable injury.[8] Such benefits are generally payable at 66 2/3 percent of the employee's average weekly wage, up to the maximum weekly benefit established by law[9] ($816 per week[10] in 2013). Indemnity benefits are generally payable for a maximum of 104 weeks, with specified exceptions.[11]

For catastrophic temporary total disability,[12] the workers' compensation law provides for increased indemnity benefits (80 percent of the employee's average weekly wage) for up to 6 months from the date of injury. Section 440.15(2)(b), F.S., limits such increased benefit to a maximum of $700 per week. As noted in the preceding paragraph, the maximum workers' compensation rate in Florida's workers' compensation system was greater than $700 for 2013. Accordingly, employees could actually receive less compensation for a catastrophic temporary total disability than they would for a non-catastrophic injury.[13]

Section 440.20(12), F.S., permits Judges of Compensation Claims or, under certain conditions, and the DFS to approve the advance payment of workers' compensation benefits to injured employees. In cases in which the carrier and employer have stipulated to an advance payment in excess of $2,000, DFS approval of the advance payment is required.

Carrier Performance Standards

Carriers are required to pay the first installment of compensation for total disability (temporary total disability or temporary partial disability) or death benefits or deny the claim within 14 days after the employer receives notification of the injury or death, when disability is immediate and continuous for 8 or more days after the injury.[14]Medical, dental, pharmacy, and hospital bills properly submitted to the insurer must be paid within 45 calendar days after receipt.[15] The DFS ensures compliance through electronic databases and carrier audits, and imposes administrative penalties against carriers that do not achieve a minimum 95 percent performance standard[16] as to either the timely payment of indemnity benefits or timely payment of medical bills.[17]

Penalties for carrier failure to timely pay medical bills are provided for in two sections of the workers' compensation law. Section 440.185, F.S., sets forth reporting requirements for employees, employers, and carriers. Employees are required to notify their employer of an injury within 30 days after the initial date of manifestation of the injury, except as otherwise specified. Employers are required to report an injury or death to their workers' compensation carrier within 7 days of having knowledge of the injury. Carriers must then report the injury to the DFS within

[8] Section 440.12(1), F.S.
[9] Sections 440.15(1)-(4), F.S.
[10] See "Informational Bulletin DFS-04-2012" (December 10, 2012). Available at http://www.myfloridacfo.com
[11] Section 440.15, F.S.
[12] The loss of an arm, leg, hand or foot, an injury that renders the employee a paraplegic, paraparetic, quadriplegic, quadriparetic, or the loss of sight in both eyes. *See* s. 440.15(2)(b), F.S.
[13] The maximum compensation rate is set in s. 440.12(2), F.S., and is equal to 100% of the statewide average weekly wage.
[14] Section 440.20(2)(a), F.S.
[15] Section 440.20(2)(b), F.S.
[16] Increased penalties are assessed against carriers that fail to achieve a minimum 90 percent performance standard for the payment of either medical or indemnity benefits.
[17] Section 440.20, F.S.

14 days. Section 440.593(4), F.S., relating to electronic reporting, authorizes the DFS to assess a civil penalty of up to $500 per violation. The DFS has indicated that it utilizes s. 440.185(9), F.S., to assess penalties for violations of reporting requirements, but that it has never assessed a penalty greater than $500 per violation or against an employer based upon a percentage of late filings.[18]

Reemployment Services and Evaluations

For injured employees who are unemployed 60 days after the date of injury, are receiving certain workers' compensation benefits, and have not been provided medical care coordination and reemployment services voluntarily by the carrier, the carrier must determine whether the employee is likely to return to work and to report its determination to the DFS and the employee. The DFS informs that the reports it receives vary from carrier to carrier, and that the DFS review of these reports is of marginal value. The DFS further reports that it has access to medical and claims data that would allow it to identify and reach out to injured employees in need of rehabilitation services and, thus, carrier submission of reemployment status reports is unnecessary.[19]

The DFS is required to conduct training and education screenings of injured employees upon referral of the carrier or employee request. Pursuant to s. 440.491(6), F.S., an employee must submit to, and the DFS must pay for, a vocational evaluation even when the employee has decided on a suitable reemployment-training plan that has been approved by the DFS. The DFS indicates that the average cost of a vocational evaluation exceeds $1,000.[20]

Miscellaneous Provisions

The DFS is the custodian of collective bargaining agreements (CBAs) that contain mutually agreed upon workers' compensation provisions (e.g., providing an alternative dispute resolution system, an agreed-upon list of medical providers, etc.). Such collectively bargained provisions may not diminish an employee's entitlement to benefits under the workers' compensation law. The DFS informs that it simply receives CBAs, does not use them in any way, and rarely ever receives a request for such documents.[21]

The Florida Self-Insurers Guaranty Association (FSIGA) monitors the financial strength of self-insured entities for the DFS and makes recommendations as to the qualifications to self-insure. Incorrect cross references within ch. 440.F.S. [reference to s. 440.38(1)(b)1., F.S., rather than s. 440.38(1)(b), F.S., in its entirety] create uncertainty as to the extent of the FSIGA's authority. The DFS is responsible for ensuring the timely payment of compensation and medical bills by workers' compensation carriers, for monitoring, auditing, and investigating carrier performance, and for assessing penalties for violations. Section 440.20, F.S., however, identifies the Office of Insurance Regulation as the regulatory body with these responsibilities.

[18] DFS correspondence, *supra*, on file with staff of the Banking and Insurance Committee.
[19] DFS correspondence, *supra*, on file with staff of the Banking and Insurance Committee.
[20] *Id.*
[21] *Id.*

Section 440.02(8), F.S., authorizes the DFS to establish, by rule, "standard industrial classification" (SIC) codes with respect to the construction industry. Similarly, s. 440.11, F.S., relating to exclusiveness of liability, refers to "Standard Industrial Code 7363." The SIC codes have been obsolete since 1997, and have been replaced with the North American Industrial Classification Code System (NAICS).

III. Effect of Proposed Changes:

Section 1 revises s. 440.02, F.S., relating to definitions to eliminate outdated references to SIC codes and to update statutory language to provide for NAICS codes.

Section 2 amends s. 440.05, F.S., relating to exemptions from coverage requirements, to eliminate the requirement of a Florida only driver's license for purposes of obtaining an exemption. The removal of this requirement will allow out-of-state officers to obtain an exemption via the electronic application process. Current practice at DFS is to accept paper applications from out-of-state applicants and issue exemptions once all other eligibility criteria are met.

Section 3 amends s. 440.102, F.S., to provide a conforming cross reference.

Section 4 amends s. 440.107, F.S., relating to enforcement of coverage requirements, to clarify that stop-work orders and penalty assessments against a LLC would be in effect for any successor entity, including a LLC.

Section 5 amends s. 440.11, F.S., to eliminate an obsolete reference to SIC codes and provide an updated reference to NAICS codes.

Section 6 amends s. 440.13, F.S., relating to medical services, to eliminate certification requirements for health care providers. Currently, certification by the DFS is a requirement for eligibility for payment under ch. 440, F.S. The bill makes conforming changes to eliminate the certification and decertification provisions.

The section allows a health care provider, carrier, or employer 45 days, rather than 30 days, to petition the DFS once a notice of disallowance or adjustment of a payment is received. Likewise, the carrier is provided 20 additional days (10 to 30) to submit documentation substantiating the disallowance or adjustment of payment. The section also provides DFS an additional 60 days (60 to 120) after receipt of all documentation to issue a written determination of a dispute.

The bill also revises provisions relating to the authority of the DFS to sanction health care providers for a pattern or practice of utilization. As an option, the DFS may impose a fine of $5,000. Currently, the DFS may impose a fine in an amount *not to exceed* $5,000.

The bill eliminates a provisions relating to the authority of the DFS to issue penalties against carriers for failure to pay medical bills in a timely manner. The DFS uses s. 440.20(6), F.S., as their authority to issue penalties.

Section 7 amends s. 440.15(2), F.S., relating to temporary total disability (TTD) benefits to eliminate the current maximum weekly compensation rate of $700. As a result, those injured workers with qualifying TTD injuries would receive 80 percent of their pre-injury average weekly wage subject to no maximum during the first 6 months of disability. Currently, injured workers' receiving TTD benefits receive 66 2/3 percent of their pre-injury average weekly wage subject to a maximum of 100 percent of the Florida state average weekly wage. The maximum workers' compensation rate for 2013 is $816. Injured workers receiving TTD benefits as a result of an injury described in s. 440.15(2)(b), F.S., are eligible to receive TTD benefits equal to 80 percent of his or her pre-injury average weekly wage. The increased TTD compensation rate of 80 percent is paid during the first 6 months of disability, subject to a maximum weekly compensation rate of $700. This increased compensation rate would only be paid if the employee is eligible for or has already started to collect permanent total disability benefits.

Section 8 amends s. 440.185, F.S., relating to reporting requirements, to revise the penalties imposed on employers and carriers for failing to file any form, report, or notice to provide that an employer or carrier would be subject to fine not to exceed $500 instead of $1,000 for each failure or refusal to file. The bill eliminates the additional penalty of $2,000 per failure if a carrier's noncompliance is more than 10 percent within a calendar year. The change in the penalty would comport the penalty with section 440.593(4), F.S., relating to electronic reporting, which authorizes the DFS to assess a civil penalty of up to $500 per violation.

Section 9 amends s. 440.20, F.S., relating to payment of compensation and medical bills to correct references relating to the authority of the DFS. The bill makes the approval of advance payment of workers' compensation benefits the sole jurisdiction of Judges of Compensation Claims, and removes the DFS from the approval process in all circumstances. Currently, section 440.20(12), F.S., permits Judges of Compensation Claims or, under certain conditions, the DFS to approve the advance payment of workers' compensation benefits to injured employees. In cases in which the carrier and employer have stipulated to an advance payment in excess of $2,000, the DFS approval of the advance payment is required.

Section 10 amends s. 440.211, F.S., to eliminate DFS as the custodian of collective bargaining agreements.

Section 11 amends s. 440.385, F.S., relating to the Florida Self-Insurers Guaranty Association, to correct a cross reference, thereby clarifying the FSIGA's authority.

Section 12 amends s. 440.491, F.S., relating to reemployment and evaluation of injured workers, to eliminate the requirement for a carrier to file reemployment status reports with DFS. Currently, a carrier must determine whether the employee is likely to return to work and report its determination to the DFS and the employee. The section is also amended to allow rather than require the DFS to provide vocational evaluations.

Section 13 provides that this act will take effect July 1, 2013.

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:

According to the National Council of Compensation Insurance, the implementation of CS/SB 860 would likely result in negligible impact (less than 0.1 percent) on the overall workers' compensation costs of employers in Florida.[22] Due to the serious nature of the qualifying injuries, NCCI expects that only a small number of prospective cases would be affected by the removal of the $700 cap on maximum weekly temporary total catastrophic benefits.

The elimination of the mandatory vocational evaluation prior to the provision of training, education, or other vocational services may allow injured workers to receive such benefits sooner and return to work in a more expeditious manner.

The bill will eliminate some reporting requirements for employers and carriers resulting in some indeterminate reduction in regulatory burden.

C. Government Sector Impact:

The bill eliminates unnecessary, duplicative, and conflicting regulatory provisions, which should assist DFS in administering the provisions of ch. 440, F.S., in a more efficient manner.

The bill eliminates the mandatory vocational evaluation under s. 440.491, F.S. The elimination of some of the evaluations could result in cost savings of approximately $80,000. This estimated savings represents less than 0.1 percent of Workers' Compensation Administration Trust Fund expenditures for FY 2010-2011.

[22] NCCI Analysis, January 28, 2013. On file with staff of the Banking and Insurance Committee.

The bill will provide additional time (from 60 days to 120 days) for the DFS to resolve reimbursement disputes and issue determination letters. According to the DFS, the DFS receives 50-200 petitions per month. For calendar year 2012, the DFS received over 2,000 petitions per month. The average number of days to resolve a case has increased from approximately 24 days to over 81 days.

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 Committee on April 9, 2013

The CS provides the following changes:

- Eliminates changes to the formula used to assess state agencies for purposes of funding workers' compensation claims of state employees.
- Eliminates changes relating to types of entities that may file medical reimbursement disputes with the DFS.

B. Amendments:

None.

563868

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 46 - 110.

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

And the title is amended as follows:

Delete lines 3 - 7

and insert:

administration; amending

793356

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 311 - 343
and insert:
(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 ~~30~~ days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the

allegations contained in the petition. Failure of a petitioner to submit such documentation to the department results in dismissal of the petition.

(b) The carrier must submit to the department within 30 ~~10~~ days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such ~~the requested~~ documentation to the department within 30 ~~10~~ days constitutes a waiver of all objections to the petition.

(c) Within 120 ~~60~~ days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and

496512

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 202 - 214
and insert:
Section 5. Paragraph (b) of subsection (7) of section 440.107, Florida Statutes, is amended, and subsection (16) is added to that section, to read:
440.107 Department powers to enforce employer compliance with coverage requirements.—
(7)
(b) Stop-work orders and penalty assessment orders issued under this section against a corporation, limited liability

496512

company, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity that has one or more of the same principals or officers as the corporation, limited liability company, or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

(16) A temporary lapse of coverage by an employer in which an employer's insurance policy is canceled for non-payment of premium and is reinstated retroactively to the date of cancellation by the employer's insurance carrier within 10 days of such cancellation may not constitute a failure by the employer to comply with the workers' compensation coverage requirements under this chapter.

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

And the title is amended as follows:

Between lines 13 and 14

insert:

prohibiting a specified lapse in coverage by an employer from constituting a failure to comply with the Workers' Compensation Law;

By Senator Galvano

26-00623-13 2013860__

A bill to be entitled

An act relating to workers' compensation system administration; amending s. 284.44, F.S.; revising duties of state agencies covered by the state risk management program with respect to funding costs for employees entitled to workers' compensation benefits; revising a definition; revising terminology; amending s. 440.02, F.S.; revising a definition; amending s. 440.05, F.S.; revising requirements relating to submitting notice of election of exemption; amending s. 440.102, F.S.; conforming a cross-reference; amending s. 440.107, F.S.; revising effectiveness of stop-work orders and penalty assessment orders; amending s. 440.11, F.S.; revising immunity from liability standards for employers and employees using a help supply services company; amending s. 440.13, F.S.; deleting and revising definitions; revising health care provider requirements and responsibilities; deleting rulemaking authority and responsibilities of the Department of Financial Services; revising provider reimbursement dispute procedures; revising penalties for certain violations or overutilization of treatment; deleting certain Office of Insurance Regulation audit requirements; deleting provisions providing for removal of physicians from lists of those authorized to render medical care under certain conditions; amending s. 440.15, F.S.; revising limitations on compensation for temporary total disability; amending s. 440.185, F.S.;

26-00623-13 2013860__

revising and deleting penalties for noncompliance relating to duty of employer upon receipt of notice of injury or death; amending s. 440.20, F.S.; transferring certain responsibilities of the office to the department; deleting certain responsibilities of the department; amending s. 440.211, F.S.; deleting a requirement that a provision that is mutually agreed upon in any collective bargaining agreement be filed with the department; amending s. 440.385, F.S.; conforming cross-references; amending s. 440.491, F.S.; revising certain carrier reporting requirements; revising duties of the department upon referral of an injured employee; providing effective dates.

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

Section 1. Effective October 1, 2013, section 284.44, Florida Statutes, is amended to read:

284.44 Medical care and ~~salary~~ indemnification costs of state agencies.—

(1) It is the intent of the Legislature, through the implementation of this section, to provide state agencies with an increased incentive to become actively involved in the prevention and management of workers' compensation claims involving state employees.

(2) State agencies covered by the state risk management program established under this part shall be responsible for funding an amount equal to 1.5 percent of all medical care and ~~initial salary~~ indemnification costs, for employees who are

entitled to workers' compensation benefits pursuant to chapter 440, from funds appropriated to pay salaries and benefits.

(3) For the purposes of this section, "medical care and ~~salary~~ indemnification costs" means the payments made to employees for their medical care for work-related injuries or as indemnification for costs resulting from work-related injuries ~~temporary total disability benefits~~. ~~After an employee has been eligible for disability benefits for 10 weeks, salary indemnification costs shall be funded from the State Risk Management Trust Fund in accordance with the provisions of this part for those agencies insured by the fund.~~

(4) For the purpose of administering this section, the Division of Risk Management of the Department of Financial Services shall continue to pay all claims~~,~~ but shall be periodically reimbursed from funds of state agencies for medical care and ~~initial salary~~ indemnification costs for which they are responsible. The amount of reimbursement due from each agency shall be calculated quarterly and billed to the agency. The amount due shall be 1.5 percent of all medical care and indemnification costs paid for agency workers' compensation claims during the quarterly billing period.

(5) If a state agency demonstrates to the Executive Office of the Governor and the chairs of the legislative appropriations committees that no funds are available to pay medical care and ~~initial salary~~ indemnification costs for a specific quarterly billing period ~~claim~~ pursuant to this section without adversely impacting its ability to perform statutory responsibilities, the Executive Office of the Governor may direct the Division of Risk Management to fund all medical care and ~~salary~~ indemnification

costs for that specific quarterly billing period ~~claim~~ from the State Risk Management Trust Fund and waive the state agency reimbursement requirement.

(6) The Division of Risk Management shall prepare quarterly reports to the Executive Office of the Governor and the chairs of the legislative appropriations committees indicating for each state agency the total amount of medical care and ~~salary~~ indemnification benefits paid to claimants and the total amount of reimbursements from state agencies to the State Risk Management Trust Fund for ~~initial~~ costs for the previous quarter. These reports shall also include information for each state agency indicating ~~the number of cases and amounts of initial salary indemnification costs for~~ which reimbursement requirements were waived by the Executive Office of the Governor pursuant to this section.

(7) If a state agency fails to pay casualty ~~increase~~ premiums or medical care and ~~salary~~ indemnification reimbursements within 30 days after being billed, the Division of Risk Management shall advise the Chief Financial Officer. After verifying the accuracy of the billing, the Chief Financial Officer shall transfer the appropriate amount from any available funds of the delinquent state agency to the State Risk Management Trust Fund.

Section 2. Subsection (8) of section 440.02, Florida Statutes, is amended to read:

440.02 Definitions.~~—~~When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(8) "Construction industry" means for-profit activities

involving any building, clearing, filling, excavation, or substantial improvement in the size or use of any structure or the appearance of any land. However, "construction" does not mean a homeowner's act of construction or the result of a construction upon his or her own premises, provided such premises are not intended to be sold, resold, or leased by the owner within 1 year after the commencement of construction. The division may, by rule, establish ~~standard industrial classification~~ codes and definitions thereof that ~~which~~ meet the criteria of the term "construction industry" as set forth in this section.

Section 3. Subsection (3) of section 440.05, Florida Statutes, is amended to read:

440.05 Election of exemption; revocation of election; notice; certification.—

(3) Each officer of a corporation who is engaged in the construction industry and who elects an exemption from this chapter or who, after electing such exemption, revokes that exemption~~,~~ must submit a notice to such effect to the department on a form prescribed by the department. The notice of election to be exempt must be ~~which is~~ electronically submitted to the department by the officer of a corporation who is allowed to claim an exemption as provided by this chapter and must list the name, federal tax identification number, date of birth, ~~Florida~~ driver license number or Florida identification card number, and all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, the registration number of the corporation filed with the Division of Corporations of the Department of State, and the percentage of

ownership evidencing the required ownership under this chapter. The notice of election to be exempt must identify each corporation that employs the person electing the exemption and must list the social security number or federal tax identification number of each such employer and the additional documentation required by this section. In addition, the notice of election to be exempt must provide that the officer electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers provided in s. 440.02, and must certify that any employees of the corporation whose officer elects an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt, receipt of all application fees, and a determination by the department that the notice meets the requirements of this subsection, the department shall issue a certification of the election to the officer, unless the department determines that the information contained in the notice is invalid. The department shall revoke a certificate of election to be exempt from coverage upon a determination by the department that the person does not meet the requirements for exemption or that the information contained in the notice of election to be exempt is invalid. The certificate of election must list the name of the corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new or different corporation that is not listed on the certificate of election. A copy of the certificate of election must be sent to each workers' compensation carrier identified in the request for exemption. Upon filing a notice of revocation of

election, an officer who is a subcontractor or an officer of a corporate subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the department, the department shall notify the workers' compensation carriers identified in the request for exemption.

Section 4. Paragraph (p) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(p) All authorized remedial treatment, care, and attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self-insurer. However, the carrier or self-insurer must have given reasonable notice to all affected health care providers that payment for treatment, care, and attendance provided to the employee after a future date certain will be denied. A health care provider, as defined in s. 440.13(1)(g) ~~440.13(1)(h)~~, that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Paragraph (b) of subsection (7) of section 440.107, Florida Statutes, is amended to read:

440.107 Department powers to enforce employer compliance with coverage requirements.—

(7)

(b) Stop-work orders and penalty assessment orders issued under this section against a corporation, limited liability company, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity that has one or more of the same principals or officers as the corporation, limited liability company, or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

Section 6. Subsection (2) of section 440.11, Florida Statutes, is amended to read:

440.11 Exclusiveness of liability.—

(2) The immunity from liability described in subsection (1) shall extend to an employer and to each employee of the employer which uses ~~utilizes~~ the services of the employees of a help supply services company, as set forth in North American Industrial Classification System Codes 561320 and 561330 ~~Standard Industry Code Industry Number 7363~~, when such employees, whether management or staff, are acting in furtherance of the employer's business. An employee so engaged by the employer shall be considered a borrowed employee of the employer~~,~~ and, for the purposes of this section, shall be treated as any other employee of the employer. The employer shall be liable for and shall secure the payment of compensation to all such borrowed employees as required in s. 440.10, except when such payment has been secured by the help supply services company.

Section 7. Paragraphs (e) through (t) of subsection (1) of section 440.13, Florida Statutes, are redesignated as paragraphs (d) through (s), respectively, subsections (14) through (17) are renumbered as subsections (13) through (16), respectively, and present paragraphs (h) and (q) of subsection (1), paragraphs (a), (c), (e), and (i) of subsection (3), subsection (7), paragraph (b) of subsection (8), paragraph (b) of subsection (11), paragraph (e) of subsection (12), and present subsections (13) and (14) of that section are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

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

~~(d) "Certified health care provider" means a health care provider who has been certified by the department or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance.~~

(g) ~~(h)~~ "Health care provider" means a physician or any recognized practitioner licensed to provide ~~who provides~~ skilled services pursuant to a prescription or under the supervision or direction of a physician ~~and who has been certified by the department as a health care provider~~. The term "health care provider" includes a health care facility.

(p) ~~(q)~~ "Physician" or "doctor" means a physician licensed

under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466~~, each of whom must be certified by the department as a health care provider~~.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services ~~must be a certified health care provider and~~ must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. ~~The department shall adopt rules to implement the certification of health care providers.~~

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider ~~that has been certified by the department~~, unless the referral is for emergency treatment, and ~~the referral~~ must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. ~~Such procedures shall be for a health care provider certified under this section.~~

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other

specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, ~~or~~ unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized ~~or certified~~, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider~~, carrier, or employer~~ who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 ~~30~~ days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The health care provider ~~petitioner~~ must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a

health care provider ~~petitioner~~ to submit such documentation to the department results in dismissal of the petition.

(b) The carrier must submit to the department within 30 ~~10~~ days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such ~~the requested~~ documentation to the department within 30 ~~10~~ days constitutes a waiver of all objections to the petition.

(c) Within 120 ~~60~~ days after receipt of all documentation, the department must provide to the health care provider ~~petitioner~~, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider~~, facility, insurer, or employer~~ within 30 days, subject to the penalties provided in this subsection.

(e) The department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a health care provider ~~petitioner~~ and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the

following penalties imposed by the department:

1. Repayment of the appropriate amount to the health care provider.

2. An administrative fine assessed by the department in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.

3. Award of the health care provider's costs, including a reasonable attorney ~~attorney's~~ fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(b) If the department determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the department, including a pattern or practice of providing treatment in excess of the practice parameters or protocols of treatment, it may impose one or more of the following penalties:

1. An order ~~of the department~~ barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

~~4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;~~

4.~~5.~~ An administrative fine of ~~assessed by the department in an amount not to exceed~~ $5,000 ~~per instance of overutilization or violation~~; and

5.~~6.~~ Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(11) AUDITS.—

(b) The department shall monitor carriers as provided in this chapter ~~and the Office of Insurance Regulation shall audit insurers and group self-insurance funds as provided in s. 624.3161, to determine if medical bills are paid in accordance with this section and rules of the department and Financial Services Commission, respectively. Any employer, if self-insured, or carrier found by the department or Office of Insurance Regulation not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The department shall fine or otherwise discipline an employer or carrier, pursuant to this chapter or rules adopted by the department, and the Office of Insurance Regulation shall fine or otherwise discipline an insurer or group self-insurance fund pursuant to the insurance code or rules adopted by the Financial Services Commission, for each late payment of compensation that is below the minimum 95-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the department or office, and an insurer or group self-insurance fund is subject to disciplinary action by the Office of Insurance Regulation~~.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(e) In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to

evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to ~~certified~~ health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey ~~certified~~ health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel.

~~(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—The department shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of~~

~~any physician or facility found after reasonable investigation to have:~~

~~(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;~~

~~(b) Exceeded the limits of his or her or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or her or its qualifications in his or her application;~~

~~(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or her or its findings to the employer or carrier as required under this chapter;~~

~~(d) Solicited, or employed another to solicit for himself or herself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;~~

~~(e) Refused to appear before, or to answer upon request of, the department or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;~~

~~(f) Self-referred in violation of this chapter or other laws of this state; or~~

~~(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the department, including failure to adhere to practice parameters and protocols established in accordance with this chapter.~~

(13) ~~(14)~~ PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider ~~certified and~~ authorized to render remedial treatment, care, or attendance under this chapter. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter. Payment to health care providers or physicians shall be subject to the medical fee schedule and applicable practice parameters and protocols, regardless of whether the health care provider or claimant is asserting that the payment should be made.

(b) Fees charged for remedial treatment, care, and attendance, except for independent medical examinations and consensus independent medical examinations, may not exceed the applicable fee schedules adopted under this chapter and department rule. Notwithstanding any other provision in this chapter, if a physician or health care provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, deviations from established fee schedules shall be permitted. Written agreements warranting deviations may include, but are not limited to, the timely scheduling of appointments for injured workers, participating in return-to-work programs with injured workers' employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance,

precertification, and case management systems that are designed to provide needed treatment for injured workers.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of $10 per visit for medical services. The copayment shall not apply to emergency care provided to the employee.

Section 8. Paragraph (b) of subsection (2) of section 440.15, Florida Statutes, is amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(2) TEMPORARY TOTAL DISABILITY.—

(b) Notwithstanding ~~the provisions of~~ paragraph (a), an employee who has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic, or has lost the sight of both eyes shall be paid temporary total disability of 80 percent of her or his average weekly wage. The increased temporary total disability compensation provided for in this paragraph must not extend beyond 6 months from the date of the accident; however, such benefits shall not be due or payable if the employee is eligible for, entitled to, or collecting permanent total disability benefits. The compensation provided by this paragraph is not subject to the limits provided in s. 440.12(2)~~, but instead is subject to a maximum weekly compensation rate of $700~~. If, at the conclusion of this period of increased temporary total disability compensation, the employee is still temporarily totally disabled, the employee shall continue to receive

temporary total disability compensation as set forth in paragraphs (a) and (c). The period of time the employee has received this increased compensation will be counted as part of, and not in addition to, the maximum periods of time for which the employee is entitled to compensation under paragraph (a) but not paragraph (c).

Section 9. Subsection (9) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(9) Any employer or carrier who fails or refuses to timely send any form, report, or notice required by this section shall be subject to an administrative fine by the department not to exceed $500 ~~$1,000~~ for each such failure or refusal. ~~If, within 1 calendar year, an employer fails to timely submit to the carrier more than 10 percent of its notices of injury or death, the employer shall be subject to an administrative fine by the department not to exceed $2,000 for each such failure or refusal.~~ However, any employer who fails to notify the carrier of an ~~the~~ injury on the prescribed form or by letter within the 7 days required in subsection (2) shall be liable for the administrative fine, which shall be paid by the employer and not the carrier. Failure by the employer to meet its obligations under subsection (2) shall not relieve the carrier from liability for the administrative fine if it fails to comply with subsections (4) and (5).

Section 10. Paragraph (b) of subsection (8) and paragraphs (a), (b), and (c) of subsection (12) of section 440.20, Florida Statutes, are amended to read:

440.20 Time for payment of compensation and medical bills; penalties for late payment.—

(8)

(b) In order to ensure carrier compliance under this chapter, the department ~~office~~ shall monitor, audit, and investigate the performance of carriers. The department ~~office~~ shall require that all compensation benefits be ~~are~~ timely paid in accordance with this section. The department ~~office~~ shall impose penalties for late payments of compensation that are below a minimum 95-percent ~~95 percent~~ timely payment performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Fifty dollars per number of installments of compensation below the 95-percent ~~95 percent~~ timely payment performance standard and equal to or greater than a 90-percent ~~90 percent~~ timely payment performance standard.

2. One hundred dollars per number of installments of compensation below a 90-percent ~~90 percent~~ timely payment performance standard.

This section does not affect the imposition of any penalties or interest due to the claimant. If a carrier contracts with a servicing agent to fulfill its administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the carrier for the purpose of assessing penalties against the carrier.

(12)

(a) Liability of an employer for future payments of compensation may not be discharged by advance payment unless

prior approval of a judge of compensation claims ~~or the department~~ has been obtained as hereinafter provided. The approval shall not constitute an adjudication of the claimant's percentage of disability.

(b) When the claimant has reached maximum recovery and returned to her or his former or equivalent employment with no substantial reduction in wages, such approval of a reasonable advance payment of a part of the compensation payable to the claimant may be given informally by letter by a judge of compensation claims ~~or by the department~~.

(c) In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:

1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.

2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto. When the parties have stipulated to an advance payment of compensation not in excess of $2,000, such advance may be approved by an order of a judge of compensation claims, with or without hearing, or informally by letter by any such judge of compensation claims~~, or by the department~~, if such advance is found to be for the best interests of the person entitled

thereto.

3. When the parties have stipulated to an advance payment in excess of $2,000, ~~subject to the approval of the department,~~ such payment may be approved by a judge of compensation claims by order if the judge finds that such advance payment is for the best interests of the person entitled thereto and is reasonable under the circumstances of the particular case. The judge of compensation claims shall make or cause to be made such investigations as she or he considers necessary concerning the stipulation and, in her or his discretion, may have an investigation of the matter made. The stipulation and the report of any investigation shall be deemed a part of the record of the proceedings.

Section 11. Subsection (1) of section 440.211, Florida Statutes, is amended to read:

440.211 Authorization of collective bargaining agreement.—

(1) Subject to the limitation stated in subsection (2), a provision that is mutually agreed upon in any collective bargaining agreement ~~filed with the department~~ between an individually self-insured employer or other employer upon consent of the employer's carrier and a recognized or certified exclusive bargaining representative establishing any of the following shall be valid and binding:

(a) An alternative dispute resolution system to supplement, modify, or replace the provisions of this chapter which may include, but is not limited to, conciliation, mediation, and arbitration. Arbitration held pursuant to this section shall be binding on the parties.

(b) The use of an agreed-upon list of ~~certified~~ health care

providers of medical treatment which may be the exclusive source of all medical treatment under this chapter.

(c) The use of a limited list of physicians to conduct independent medical examinations which the parties may agree shall be the exclusive source of independent medical examiners pursuant to this chapter.

(d) A light-duty, modified-job, or return-to-work program.

(e) A vocational rehabilitation or retraining program.

Section 12. Paragraph (b) of subsection (1) of section 440.385, Florida Statutes, is amended to read:

440.385 Florida Self-Insurers Guaranty Association, Incorporated.—

(1) CREATION OF ASSOCIATION.—

(b) A member may voluntarily withdraw from the association when the member voluntarily terminates the self-insurance privilege and pays all assessments due to the date of such termination. However, the withdrawing member shall continue to be bound by the provisions of this section relating to the period of his or her membership and any claims charged pursuant thereto. The withdrawing member who is a member on or after January 1, 1991, shall also be required to provide to the association upon withdrawal, and at 12-month intervals thereafter, satisfactory proof, including, if requested by the association, a report of known and potential claims certified by a member of the American Academy of Actuaries, that it continues to meet the standards of s. 440.38(1)(b) ~~440.38(1)(b)1.~~ in relation to claims incurred while the withdrawing member exercised the privilege of self-insurance. Such reporting shall continue until the withdrawing member demonstrates to the

association that there is no remaining value to claims incurred while the withdrawing member was self-insured. If a withdrawing member fails or refuses to timely provide an actuarial report to the association, the association may obtain an order from a circuit court requiring the member to produce such a report and ordering any other relief that the court determines appropriate. The association is entitled to recover all reasonable costs and attorney ~~attorney's~~ fees expended in such proceedings. If during this reporting period the withdrawing member fails to meet the standards of s. 440.38(1)(b) ~~440.38(1)(b)1.~~, the withdrawing member who is a member on or after January 1, 1991, shall thereupon, and at 6-month intervals thereafter, provide to the association the certified opinion of an independent actuary who is a member of the American Academy of Actuaries of the actuarial present value of the determined and estimated future compensation payments of the member for claims incurred while the member was a self-insurer, using a discount rate of 4 percent. With each such opinion, the withdrawing member shall deposit with the association security in an amount equal to the value certified by the actuary and of a type that is acceptable for qualifying security deposits under s. 440.38(1)(b). The withdrawing member shall continue to provide such opinions and to provide such security until such time as the latest opinion shows no remaining value of claims. The association has a cause of action against a withdrawing member, and against any successor of a withdrawing member, who fails to timely provide the required opinion or who fails to maintain the required deposit with the association. The association shall be entitled to recover a judgment in the amount of the actuarial present

value of the determined and estimated future compensation payments of the withdrawing member for claims incurred during the time that the withdrawing member exercised the privilege of self-insurance, together with reasonable attorney ~~attorney's~~ fees. The association is also entitled to recover reasonable attorney ~~attorney's~~ fees in any action to compel production of any actuarial report required by this section. For purposes of this section, the successor of a withdrawing member means any person, business entity, or group of persons or business entities, which holds or acquires legal or beneficial title to the majority of the assets or the majority of the shares of the withdrawing member.

Section 13. Paragraph (a) of subsection (3) and paragraph (a) of subsection (6) of section 440.491, Florida Statutes, are amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(3) REEMPLOYMENT STATUS REVIEWS AND REPORTS.—

(a) When an employee who has suffered an injury compensable under this chapter is unemployed 60 days after the date of injury and is receiving benefits for temporary total disability, temporary partial disability, or wage loss~~,~~ and has not yet been provided medical care coordination and reemployment services voluntarily by the carrier, the carrier must determine whether the employee is likely to return to work and must report its determination to ~~the department and~~ the employee. The report shall include the identification of both the carrier and the employee, ~~and~~ the carrier claim number, and any case number assigned by the Office of the Judges of Compensation Claims. The carrier must thereafter determine the reemployment status of the

employee at 90-day intervals as long as the employee remains unemployed, is not receiving medical care coordination or reemployment services, and is receiving the benefits specified in this subsection.

(6) TRAINING AND EDUCATION.—

(a) Upon referral of an injured employee by the carrier, or upon the request of an injured employee, the department shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation ~~and, if appropriate~~, approve training and education, or approve other vocational services for the employee. At the time of such referral, the carrier shall provide the department a copy of any reemployment assessment or reemployment plan provided to the carrier by a rehabilitation provider. The department may not approve formal training and education programs unless it determines, after consideration of the reemployment assessment, that the reemployment plan is likely to result in return to suitable gainful employment. The department may ~~is authorized to~~ expend moneys from the Workers' Compensation Administration Trust Fund, established by s. 440.50, to secure appropriate training and education at a Florida public college or at a career center established under s. 1001.44, or to secure other vocational services when necessary to satisfy the recommendation of a vocational evaluator. As used in this paragraph, "appropriate training and education" includes securing a general education diploma (GED), if necessary. The department shall by rule establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs. For purposes of this subsection, training and

education services may be secured from additional providers if:

1. The injured employee currently holds an associate degree and requests to earn a bachelor's degree not offered by a Florida public college located within 50 miles from his or her customary residence;

2. The injured employee's enrollment in an education or training program in a Florida public college or career center would be significantly delayed; or

3. The most appropriate training and education program is available only through a provider other than a Florida public college or career center or at a Florida public college or career center located more than 50 miles from the injured employee's customary residence.

Section 14. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4.9.13
Meeting Date

Topic Workers' Comp

Bill Number 860 *(if applicable)*

Name Ashley Mayer

Amendment Barcode _____ *(if applicable)*

Job Title Dir. Leg & Cabinet Affairs

Address Capitol, PL-11
Street
Tallahassee FL
City *State* *Zip*

Phone 413-2863

E-mail ashley.mayer@myfloridacfo.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Dep't Financial Services

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)

4/9
Meeting Date

Topic _____ Bill Number 960 *(if applicable)*

Name Leslie Dughi Amendment Barcode _____ *(if applicable)*

Job Title _____

Address _____ Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Representing Associated Industries

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 Committee on Banking and Insurance

BILL:	CS/SB 1128
INTRODUCER:	Banking and Insurance Committee and Health Policy Committee
SUBJECT:	Health Flex Plans
DATE:	April 9, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall		**hp SB 7014 as introduced**
2.	Johnson	Burgess	BI	**Fav/CS**
3.			CA	
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:

CS/SB 1128 eliminates the repeal of the Health Flex Program, which is designed to provide affordable, alternative health care coverage for low-income individuals. Without legislative action, the Health Flex program would sunset on July 1, 2013. The bill also allows Health Flex plans coverage to include excepted benefits, such as hospital indemnity or other fixed indemnity insurance, and limited scope dental or vision effective January 1, 2014. Currently, such coverage is health care services that are covered as benefits provided under an approved Health Flex plan or otherwise provided either directly or through arrangements with other persons, via a Health Flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

This bill substantially amends section 408.909, Florida Statutes.

II. Present Situation:

The Health Flex program was created by the 2002 Legislature to address the health insurance needs of Florida's lower income uninsured adult population.[1] At the time, Florida's uninsured

[1] SB 46-E (2003-E Session).

rate was reported as 16.8 percent, or 2.1 million while for those under 150 percent of the federal poverty level (FPL) the rate was reported at 34 percent.[2] Initially launched as a pilot program limited to three areas of the state with the highest incidences of uninsured adults and Indian River County, the program had an original expiration date of July 2004.[3]

Subsequent legislative acts removed the limited geographic reach of the project extending the scope statewide as well as modified the expiration date multiple times until it reached its current expiration date of June 30, 2013.[4] Plans are currently available in six counties: Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie.[5]

The enacting legislation's intent emphasized alternative approaches for affordable health care options over traditional insurance coverage for the uninsured. Products offered as Health Flex plans were to include basic and preventive health care services and to coordinate with local service programs.[6]

Health Flex plans can be offered through a variety of means, including by licensed insurers, health maintenance organizations (HMOs), health care providers, local governments, health care districts or other public or private organizations.[7] Products sold under the program are not subject to the Florida Insurance Code.[8] As of September 30, 2012, three plans cover 12,127 members.[9]

Plan Name	Enrollment – September 30, 2012
American Care, Inc.	347
Preferred Medical Plan, Inc.	1,630
Vita Health Plan, Inc.	10,150
Total Enrollment:	**12,127**

Eligibility for the program has also been modified multiple times since inception. Today, an individual must meet the following requirements:[10]

- Be a resident of the state;
- Have a family income equal to or less than 300 percent FPL ($69,150 for a family of four based on 2012 federal guidelines);
- Not be covered by a private insurance policy and not be eligible for public coverage such as Medicare, Medicaid, or KidCare, or have not been covered at anytime in the last 6 months;

[2]Analysis for SB 46-E by the Senate Committee on Health, Aging and Long Term Care (April. 30, 2002), *available at http://archive.flsenate.gov/data/session/2002E/Senate/bills/analysis/pdf/2002s0046E.hc.pdf (*last visited Feb. 11, 2013).
[3] Id.
[4]*See Chapter Law 2003-405, Chapter Law 2004-270, Chapter Law 2005-231, Chapter Law 2008-32, Chapter Law 2011-195.*
[5]Florida Agency for Health Care Administration and Florida Office of Insurance Regulation, *Health Flex Plan Program, Annual Report*, 3-5, (January 2013).
[6]SB 46-E (2003-E Session).
[7]s. 408.909(1), F.S.
[8]s. 408.909(4), F.S., *supra at n. 2.*
[9]*Supra*, note 5 at 5-6.
[10]*Supra*, note 5, at p. 2-3.

- Have applied for health care coverage through an approved Health Flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or,
- Be part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the Health Flex plan entity is a health insurer, health plan or HMO, only 50 percent of the employees must meet the income requirement.

In addition, if a person did have coverage in the past 6 months under an individual health maintenance organization (HMO) contract licensed in the Florida which was also a licensed Health Flex plan on October 1, 2008, the individual may apply for coverage under that same Health Flex plan without a lapse in coverage if all other eligibility requirements are met. If a person was covered under Medicaid or KidCare and lost eligibility for Medicaid or KidCare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan, the individual may apply for coverage in a Health Flex plan without a lapse in coverage if all other eligibility requirements are met.

Responsibility for the Health Flex program resides with both the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (OIR). The Agency and the OIR jointly review applications for Health Flex plans, develop necessary rules, evaluate the program, and produce an annual report. The Agency has primary responsibility for reviewing Health Flex applications and determining whether plans meet quality of care standards and follow standard grievance procedures. The OIR is responsible for monitoring the financial condition of each plan.

Under s. 408.909(4), F.S., the Health Flex plans are not subject to the licensing requirements of the Florida Insurance Code or ch. 641, F.S., relating to HMOs, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, Health Flex plans are considered insurance subject to the applicable provisions of part IX of chapter 626, F.S., except as otherwise provided. The plans are not required to cover Florida's mandated benefits or meet solvency requirements. Neither do the current benefits schedules of the Health Flex plans comply with the essential health coverage as the packages do not offer all ten essential health benefit categories based on a review of the web-based marketing materials for the three plans.[11]

In March 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[12] Beginning January 1, 2014, the federal government and some states plan to launch one of the largest components of the PPACA legislation, health benefits exchanges.[13] The exchange implementation coincides with the requirement that, with few exceptions, all individuals must maintain a minimum level of health insurance coverage for themselves and

[11]Websites for three Health Flex plans reviewed on February 12, 2013: American Care Plans, *Health Flex Plans,* *http://www.healthflex.org/files/HealthFlexBrochure.pdf*, Preferred Medical Plan, Medi-Flex Plan, https://www.pmphmo.com/plans.php, and Vita Health Plan, http://www.vitahealth.org/index.aspx?page=453, (last visited Feb. 11, 2013).
[12]Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[13]*Id.*

their dependants.[14] Subsidies, advanced premium tax credits, and out of pocket cost sharing maximums become effective at the same time to assist lower income enrollees with the cost of that coverage.[15] These premium assistance measures assist individuals at varying levels from 100 percent FPL up to 400 percent FPL ($45,960 for an individual in 2013).[16]

Health care coverage will be available through Medicaid or the Children's Health Insurance Program (CHIP) for the lowest income individuals. Children are covered under Medicaid or CHIP in Florida currently up to 200 percent FPL.[17] The state may also elect to extend Medicaid eligibility to adults up to 133 percent FPL.[18, 19]

Under PPACA, a state may operate its own exchange, partner with the federal government, or default to a federal exchange.[20] Regardless of the option selected by a state, individuals will have a choice of qualified health plans that meet established standards and offer the minimum set of essential health benefits. In order to be offered on the exchanges, a health plan has to offer the benefits in ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.[21]

The essential health benefits requirement does not apply to all plans, including certain self-insured group plans, health insurance coverage offered in the large group market, and grandfathered health plans.[22] Individuals who do not maintain health insurance coverage that meets the PPACA minimum requirements and cannot show a hardship or meet some other allowable exemption, will be subject to a tax penalty.[23] To qualify for the hardship exemption, an individual who is not eligible for Medicaid and who is above the filing threshold for income taxes must show that the cost of his or her contribution towards self-only coverage for a calendar year will exceed 8 percent of household income.[24]

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[14]Hinda Chaikind, *Individual Mandate and Related Information Requirements under PPACA*¸ Congressional Research Service, 1, (September 21, 2010), *http://www.ncsl.org/documents/health/Individual_Mandate_Under_PPACA_pdf.*, *(*last visited Feb. 11, 2013).

[15]Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (July 2012), http://www.kff.org/healthreform/upload/7962-02.pdf (last visited Feb. 13, 2013).

[16]78 FR 5182 (5182-5183), January 24, 2013.

[17]State of Florida, Florida KidCare Program, Title XXI State Plan, *Amendment #22, (5),* http://www.fdhc.state.fl.us/medicaid/medikids/PDF/KidCare_Program_Amendment_21_to_Titlle_XXI_2012-07-01.pdf , (last visited Feb. 11, 2013).

[18]*Supra, Note 10.*

[19]*National Federal of Independent Business (NFIB) et al v. Sebelius,* 567 U.S., ___(2012).

[20]Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *General Guidance on Federally-facilitated Exchanges*, (May 16, 2012), http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf (last visited Feb. 11, 2013).

[21] Healthcare.gov., http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Feb. 11, 2013).

[22] PPACA exempts "grandfathered health plan coverage" from many of its insurance requirements. For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. PPACA s. 1251; 42 U.S.C. s. 18011; 45 C.F.R. s. 147.140.

[23] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).

[24] Chaikind, *supra* Note 13 at 3.

Under the federal definitions of health insurance coverage, coverage includes medical and hospital benefits that are offered by an issuer licensed in the state and whose coverage is regulated by that state.[25] Some insurance coverage may meet the definition of excepted benefits, which would not qualify as minimum essential coverage for the individual mandate.[26] Examples of excepted benefits would include coverage limited to dental or on-site medical clinics.[27] Excepted benefit plans are not required to provide the essential health benefits.

III. Effect of Proposed Changes:

The bill eliminates the repeal of the Health Flex program that was scheduled to be effective July 1, 2013. Instead, the bill eliminates any reference to a termination date. Effective January 1,2 014, the bill also allows Health Flex plans coverage to include excepted benefits (such as hospital indemnity or other fixed indemnity insurance, and limited scope dental or vision), as provided in s. 627.6561(5)(b),(c), and (d), F.S. Currently, coverage is health care services that are covered as benefits provided under an approved Health Flex plan or otherwise provided either directly or through arrangements with other persons, via a Health Flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

This act would take effect June 30, 2013.

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:

Currently, individuals eligible for enrollment in the Health Flex program are at or below 300 percent FPL. Under PPACA, premium tax credits, and subsidies would be available for qualified individuals between 100 FPL and 400 FPL who obtain coverage in the

[25] 42 U.S.C. s.300gg-91(b).
[26] Chaikind, *supra* note 13, at 1-2.
[27] 42 U.S.C. s. 300gg-91(c)

exchange. It is anticipated that many individuals above 100 FPL may transition to the exchange.

However, individuals below 100 FPL are not eligible for premium tax credits or subsidies through an exchange. If Florida elects not to expand Medicaid for adults to 133 percent FPL, there may be a gap in subsidized coverage options for individuals under 100 percent FPL. The bill would continue access to affordable, alternative coverage through the Health Flex plan.

C. Government Sector Impact:

One plan, Vita offered by the Health Care District of Palm Beach County, offsets the cost of coverage. The Health Care District currently subsidizes approximately two thirds of the total premium with the enrollee paying the remaining one third of the total premium.[28] The estimated number of individuals that would transition from Health Flex plans to the exchange is indeterminate at this time. The fiscal impact on the District is unknown at this time.

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 April 9, 2013:
The CS eliminates the sunset date of the Health Flex program and also allows such coverage to include excepted benefits as well as current benefits specified in s. 408.909(2)(d), F.S.

B. Amendments:

None.

[28] *Supra*, Note 5, at 6.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (2) and subsection (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.—

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

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a

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health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis. Effective January 1, 2014, the terms include one or more of the excepted benefits under s. 627.6561(5)(b), the benefits under s. 627.6561(5)(c) if offered separately, or the benefits under s. 627.6561(5)(d) if offered as independent, noncoordinated benefits.

~~(10) EXPIRATION.—This section expires July 1, 2013.~~

Section 2. This act shall take effect June 30, 2013.

========== 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 health flex plans; amending s. 408.909, F.S.; revising the definition of the terms "health care coverage" or "health flex plan coverage" to include certain specified benefits; deleting the section's expiration date; providing an effective date.

By the Committee on Health Policy

588-01738-13 20131128__

A bill to be entitled

An act relating to health flex plans; amending s. 408.909, F.S.; revising the expiration date to extend the availability of health flex plans to low-income uninsured state residents; providing an effective date.

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

Section 1. Subsection (10) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(1) INTENT.—The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

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

(a) "Agency" means the Agency for Health Care

588-01738-13 20131128__

Administration.

(b) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(c) "Enrollee" means an individual who has been determined to be eligible for and is receiving health care coverage under a health flex plan approved under this section.

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, other public or private community-based organization, or public-private partnership that develops and implements an approved health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PROGRAM.—The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers

offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices;

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(4) LICENSE NOT REQUIRED.—Neither the licensing requirements of the Florida Insurance Code nor chapter 641, relating to health maintenance organizations, is applicable to a health flex plan approved under this section, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, health flex plans are considered to be insurance subject to the applicable provisions of part IX of chapter 626, except as otherwise provided in this section.

(5) ELIGIBILITY.—Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a)1. Have a family income equal to or less than 300 percent of the federal poverty level;

2. Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

3. Have applied for health care coverage as an individual through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

(b) Are part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

(6) RECORDS.—Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the office to monitor and determine the financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

(7) NOTICE.—The denial of coverage by a health flex plan,

or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. If the health flex plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.—Coverage under an approved health flex plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, or any other political subdivision of this state, or against the agency, for failure to make coverage available to eligible persons under this section.

(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 1, 2005, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(10) EXPIRATION.—This section expires January 1, 2014, or upon the availability of qualified health plans through an exchange, whichever occurs later ~~July 1, 2013~~.

Section 2. This act shall take effect June 30, 2013.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1302
INTRODUCER:	Banking and Insurance Committee and Senator Garcia
SUBJECT:	Temporary Certificates for Visiting Physicians
DATE:	April 9, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/1 amendment**
2.	Harkey	Klebacha	ED	**Favorable**
3.	Knudson	Burgess	BI	**Fav/CS**
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:

CS/SB 1302 amends the requirements for issuance of a temporary certificate for visiting physicians to obtain medical privileges for instructional purposes. The types of training programs and educational symposiums for visiting faculty for which a medical doctor may seek a temporary certificate are expanded beyond the current subject matter of plastic surgery to include other medical or surgical training programs. The types of entities that may sponsor the training programs are expanded to recognize additional organizations and would include any other medical or surgical society in conjunction with a medical school or teaching hospital as defined in s. 408.07, F.S.

Temporary certificates will be issued on a per symposium basis rather than a fixed number per year and are set to 12 per symposium. The number of days that each temporary certificate is valid is also increased from 3 days per year to 5, and the certificate expires 1 year after issuance.

This bill takes effect July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 458.3137.

II. Present Situation:

Regulation of the Practice of Medicine

Chapter 458, F.S., provides for the regulation of the practice of medicine by the Board of Medicine. Any person who wishes to practice as a medical physician must be licensed and meet specified criteria which include:

- Being at least 21 years of age;
- Being of good moral character;
- Not having committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, F.S.;
- Completion of the equivalent of 2 academic years of pre-professional, postsecondary education with certain minimum courses prior to entering medical school;
- Meeting certain medical education and post graduate training requirements;
- Submitting fingerprints and a background check to the Department of Health (DOH); and
- Obtaining a passing score on a specified medical licensure examination.

Section 458.3145(6), F.S., provides requirements for a distinguished scholar to be issued a temporary medical faculty certificate to teach for a time-limited period at a medical school or teaching hospital. The certificate may be issued to a physician who has been requested by the dean of an accredited medical school or the medical director of a statutory teaching hospital within the state to practice only within that facility or its affiliated clinical facilities. The certificate-holder must demonstrate financial responsibility by either having medical malpractice insurance, holding an escrow account or a letter of credit in the specified amounts required by s. 458.320, F.S., or be exempt from the financial responsibility requirements as an officer, employee, or agent of the federal or state government.

Section 458.3135, F.S., provides a mechanism for the issuance of temporary certificates to visiting international physicians who may practice in board-approved cancer centers. Such visiting physicians are under training, under the direct supervision of a physician, or under contract with an approved cancer center for a period of no more than 1 year. To be issued a temporary certificate without an examination, the visiting international physician must be an individual who:

- Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;
- Holds a valid, unencumbered license to practice medicine in another country;
- Has completed the application form and remitted the nonrefundable fee;
- Meets the financial responsibility requirements of s. 458.320, F.S.; and
- Has been accepted for a course of training by a cancer center approved by the Board of Medicine.

A recipient of a temporary certificate is exempt from the practitioner profiling requirements, but all other provisions of ch. 456 or ch. 458, F.S., apply. The maximum number of temporary certificates that may be issued by the board may not exceed 10 per each cancer center.

Grounds for Physician Discipline

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance in the DOH. Section 456.072, F.S., specifies 40 acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. The various disciplinary actions that may be taken are also specified in this section. Section 458.331, F.S., identifies 43 acts that constitute grounds for which disciplinary actions may be taken against a medical physician.

Financial Responsibility

Section 458.320, F.S., requires Florida-licensed allopathic physicians to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Under s. 458.320(2), F.S., physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim. Physicians without hospital privileges, under s. 458.320(1), F.S., must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Under s. 458.320(5), F.S., such sign or statement must specifically state:

> Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Florida-licensed osteopathic physicians have similar financial responsibility requirements under s. 459.0085, F.S. With specified exceptions, the DOH must suspend on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.

III. Effect of Proposed Changes:

Section 1 amends s. 458.3137, F.S., to modify the conditions under which a temporary certificate for visiting physicians for instructional purposes may be granted. The bill expands the type of training programs eligible for temporary certificates to include other medical and surgical training programs, not just plastic surgery educational symposiums. The bill provides an expanded list of acceptable affiliations that the training programs may be associated with, including the following: a medical or surgical training program associated with a medical school in this state that is accredited

by the American Council for Graduate Medical Education, the American Osteopathic Association, or one that is part of a teaching hospital as defined in s. 408.07, F.S. The bill expands the types of symposiums a physician could be invited to by providing that a physician could be invited to an event cosponsored by the American Society of Plastic Surgeons, the Plastic Surgery Educational Foundation, the American Society for Aesthetic Plastic Surgery, or any other medical or surgical society in conjunction with a medical school or teaching hospital. Currently, only symposiums related to plastic surgery are covered under the temporary certificates.

The bill authorizes the temporary certificate without examination for educational purposes to help teach plastic surgery or other medical and surgical procedures in training programs affiliated with medical schools that are accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or that is part of a teaching hospital, or to residents of a state medical school, or if part of an educational symposium held by a state medical school or teaching hospital. This modification expands the type of procedures and the accrediting organizations for the educational symposiums covered under the temporary certificates.

The bill modifies the requirement that the individual be an expert in plastic surgery or another field of medicine or surgery to conform to other changes in the statute. The individual physician seeking the temporary certificate must also be applying in connection with one of the training programs covered by this section of law.

The bill authorizes the DOH to issue up to 12 temporary certificates for a single educational symposium. Each temporary certificate is valid for up to 5 days. Current law limits the DOH to issuing 6 certificates per year with each certificate is valid for no more than 3 days per year. Certificates expire 1 year after issuance.

The bill modifies the requirements for proof of financial responsibility for medical malpractice for physicians holding a temporary certificate by providing as an additional option for physicians not licensed in this country proof that the physician is covered under the medical malpractice insurance of a teaching hospital or medical school. The amount of the bond, certificate of deposit, or guaranteed letter of credit continues to be at least $250,000.

Section 2 provides an effective date of July 1, 2013.

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:

Applicants for the temporary certificate to practice medicine to help teach plastic surgery and other medical or surgical training programs in conjunction with a nationally sponsored educational symposium will be required to pay an application fee of no more than $300.

B. Private Sector Impact:

Expanding temporary certificates to other medical and surgical training programs may result in additional educational symposiums, choosing Florida as a conference location.

C. Government Sector Impact:

The DOH implemented the original bill in 2003. While this bill expands the number of certificates that could be issued per year, the DOH's fiscal analysis indicates that impact is indeterminate as the number of applications that could be received is unknown.

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 April 9, 2013:
The CS authorizes medical schools to provide medical malpractice insurance for visiting foreign physicians who are seeking a temporary certificate.

B. Amendments:

None.

By Senator Garcia

38-01205A-13 20131302__

A bill to be entitled

An act relating to temporary certificates for visiting physicians; amending s. 458.3137, F.S.; providing that a physician who has been invited by certain medical or surgical training programs or educational symposiums may be issued a temporary certificate for limited privileges solely to provide educational training; modifying criteria; revising the requirements for proof of medical malpractice insurance; providing an effective date.

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

Section 1. Section 458.3137, Florida Statutes, is amended to read:

458.3137 Temporary certificate for visiting physicians to obtain medical privileges for instructional purposes in conjunction with certain plastic surgery or other medical or surgical training programs and ~~plastic surgery~~ educational symposiums.—

(1) A ~~any~~ physician who has been invited by ~~both~~:

(a) A plastic surgery or other medical or surgical training program ~~that is~~ affiliated with a medical school in ~~within~~ this state which ~~that~~ is accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or which is part of a teaching hospital as defined in s. 408.07; or ~~and~~

(b) An educational symposium cosponsored by the American Society of Plastic Surgeons, the Plastic Surgery Educational

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Foundation, ~~or~~ the American Society for Aesthetic Plastic Surgery, or any other medical or surgical society in conjunction with a medical school or teaching hospital as defined in s. 408.07,

may be issued a temporary certificate for limited privileges solely for purposes of providing educational training in plastic surgery or other medical or surgical procedures, as appropriate, in accordance with the restrictions set forth in this section.

(2) A temporary certificate to practice medicine for educational purposes to help teach plastic surgery or other medical or surgical procedures to residents in a training program affiliated with a medical school that is accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or that is part of a teaching hospital, or to residents of a medical school within this state in conjunction with a nationally sponsored educational symposium or an educational symposium held by a state medical school or teaching hospital, may be issued without examination, upon verification by the board that the individual ~~meets all of the following requirements~~:

(a) Is a graduate of an accredited medical school or its equivalent or is a graduate of a foreign medical school listed with the World Health Organization.

(b) Holds a valid and unencumbered license to practice medicine in another state or country.

(c) Is a recognized expert in a specific area of plastic surgery or another field of medicine or surgery, as demonstrated by peer-reviewed publications, invited lectureships, and

academic affiliations.

(d) Has completed an application form adopted by the board and remitted a nonrefundable application fee not to exceed $300.

(e) Has not committed an act in this or any other jurisdiction that would constitute a basis for disciplining a physician under s. 456.072 or s. 458.331.

(f) Meets the financial responsibility requirements of s. 458.320(1) or (2).

(g) Is applying only in connection with a training program or an educational symposium as described in subsection (1) ~~both a medical school within this state that is accredited by the Accreditation Council for Graduate Medical Education and an educational symposium sponsored by the American Society of Plastic Surgeons, the Plastic Surgery Educational Foundation, or the American Society for Aesthetic Plastic Surgery~~.

(3) A temporary certificate issued under this section is valid for up to 5 ~~no more than 3~~ days per year~~,~~ and ~~such certificate~~ expires 1 year after issuance.

(4) The department may ~~shall~~ not issue more than 12 ~~six~~ temporary certificates for a single educational symposium under this section ~~per calendar year~~.

(5) In order for a physician who is a graduate of a foreign medical school and holds a valid and unencumbered license to practice medicine in another country but does not hold a license to practice medicine in this or another state to obtain a temporary certificate under this section, the organization sponsoring the educational symposium must pay for any medical judgments incurred by that physician by obtaining a surety bond issued by a surety company authorized to do business in this

state, by ~~or~~ establishing a certificate of deposit or a guaranteed letter of credit with a licensed and insured bank or savings institution located in the state, or by providing proof that the physician is covered under a teaching hospital's medical malpractice insurance. The amount of the bond, certificate of deposit, or guaranteed letter of credit must ~~shall~~ be at least ~~an amount not less than~~ $250,000.

(6) A physician applying under this section is exempt from the requirements of ss. 456.039-456.046. All other provisions of chapter 456 and this chapter apply.

(7) The board may ~~shall~~ not issue a temporary certificate for practice to any physician who is under investigation in another jurisdiction for an act that would constitute a violation of this chapter or chapter 456 until such time as the investigation is complete and the physician is found innocent of all charges.

Section 2. This act shall take effect July 1, 2013.

516098

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/14/2013	.	
	.	
	.	
	.	

The Committee on Health Policy (Garcia) recommended the following:

Senate Amendment

Delete line 91
and insert:
that the physician is covered under a teaching hospital's or medical school's

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1498
INTRODUCER:	Senator Brandes
SUBJECT:	Sinkhole Insurance
DATE:	April 5, 2013
REVISED:	

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

I. Summary:

SB 1498 changes the insurer's payment responsibility when a sinkhole loss is verified. The bill requires the insurer to "pay to stabilize the structure." Current law requires the insurer to pay, "to stabilize the land and building and repair the foundation." A policyholder who is paid by the insurer to stabilize the structure must also repair the sinkhole. The method used to stabilize the structure must be warranted for the lifetime of the structure. The bill amends the definition of structural damage by requiring use of the 2007 edition of the Florida Building Code to define when the interior building structure or members are unfit for service or represent a safety hazard as a result of interior floor displacement.

The bill specifies that the insured and insurer jointly own a sinkhole testing report and requires two original reports to be sent to the insured and a copy to the insurer. The bill imposes a $25 per day penalty for each day that an insurer fails to file a copy of the sinkhole report and certification with the clerk of court within 30 days after paying a sinkhole claim.

The effective date is July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 627.706, 627.707, and 627.7073.

II. Present Situation:

Sinkhole Insurance

Under current law, insurers offering property insurance must make available to policyholders, for an appropriate additional premium, sinkhole coverage for losses on any structure, including personal property contents.[1] Sinkhole coverage includes repairing the home, stabilizing the underlying land, and foundation repairs. Insurance companies must also provide coverage for catastrophic ground cover collapse.[2] Insurers may restrict catastrophic ground cover collapse and sinkhole loss coverage to the principal building as defined in the insurance policy. An insurer may require a property inspection prior to issuing sinkhole loss coverage.

Sinkhole coverage is payable when a "sinkhole loss" occurs.[3] A sinkhole loss is defined in statute as structural damage to the covered building, including the foundation, caused by sinkhole activity.[4] The bill creates a detailed definition of "structural damage" for purposes of determining whether a sinkhole loss has occurred.[5] The definition specifies five distinct types of damage that constitute structural damage. Each type of damage is tied to standards contained in the Florida Building Code or used in the construction industry. "Sinkhole activity" is the settlement or systematic weakening of the earth supporting the covered building that results from contemporaneous movement or raveling of soils, sediments, or rock into subterranean voids created by the effect of water on a limestone or similar rock formation.[6] Accordingly, in order for the policyholder to obtain policy benefits for sinkhole loss, the insured structure must sustain structural damage that is caused by sinkhole activity.

Sinkhole insurance claims increased substantially both in number and cost over the past two decades and most dramatically over the last several years.[7] The drastic increase in sinkhole claims is harming the financial stability of Citizens Property Insurance Corporation (Citizens) and private market insurers and making residential property insurance increasingly unaffordable or unavailable for consumers. According to data submitted in 2011 by 211 property insurers to the Office of Insurance Regulation (OIR), the insurers' total reported claims increased from 2,360 in 2006 to 6,694 in 2010, totaling 24,671 claims throughout that period.[8] Total sinkhole claim costs for these insurers amounted to approximately $1.4 billion for the same period.[9] These losses resulted in large premium increases for sinkhole coverage, particularly in Hillsborough, Pasco, and Hernando counties. The 2011 Legislature enacted legislation in (CS/CS/CS/SB 408) to address the large increases in sinkhole policyholder premiums and losses.

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[1] S. 627.706, F.S.
[2] Catastrophic ground cover collapse refers to extreme damage in which a property is essentially destroyed and uninhabitable.
[3] See s. 627.706(1)(b), F.S., and s. 627.707(5), F.S.
[4] S. 627.706(2)(j), F.S.
[5] S. 627.706(2)(k), F.S.
[6] S. 627.706(2)(i), F.S.
[7] The increase in claims frequency and severity is based on data collected from 211 insurers by the Office of Insurance Regulation (OIR) in the Fall of 2010, (*Report on Review of the 2010 Sinkhole Data Call* (OIR Report),
[8] The sources for the report included sinkhole policy and claims information collected from 211 insurers for the period 2006 to 2010, pursuant to a data call by the Office of Insurance Regulation. The report also utilized policy and claims data submitted by Citizens Property Insurance Corporation, individual insurers as well as background and research information collected by committee staff.
[9] See id.

Investigation of Sinkhole Claims

Upon receiving a sinkhole claim, the insurer must investigate the claim to determine whether the building has incurred structural damage that has been caused by sinkhole activity. The insurer is not required to pay benefits for sinkhole loss if structural damage is not present or sinkhole activity is not the cause of the structural damage. The claim investigation process is as follows:

- *Initial Inspection and Structural Damage Determination*: Upon receipt of a claim for sinkhole loss, the insurer must inspect the policyholder's premises to determine if there has been structural damage which may be the result of sinkhole activity. This inspection will often require the insurer to retain a professional engineer to evaluate whether the insured building has incurred structural damage as defined by statute.
- *Sinkhole Testing Initiated by the Insurer*: The insurer is required to engage a professional engineer or professional geologist to conduct sinkhole testing pursuant to s. 627.7072, F.S., if the insurer confirms that structural damage exists and is either unable to identify a valid cause of the structural damage or discovers that the structural damage is consistent with sinkhole loss. Upon the completion of sinkhole testing, the professional engineer must issue a report and certification that details whether the testing verified a sinkhole loss.
- *Authorization to Deny Sinkhole Claim*: Insurers may deny the claim upon a determination that there is no sinkhole loss.
- *Policyholder Demand for Sinkhole Testing*: The policyholder may demand sinkhole testing in writing within 60 days after receiving a claim denial if the insurer denies the claim without performing sinkhole testing and coverage would be available if a sinkhole loss is confirmed (i.e. the claim denial was not issued due to policy conditions or exclusions of coverage and instead was based on the failure of the loss to meet the definition of sinkhole loss). However, if the policyholder requests such testing, it must pay the insurer 50 percent of the sinkhole testing costs up to $2,500. If the requested testing confirms a sinkhole loss, the insurer must reimburse the testing costs to the policyholder.

Neutral Evaluation of Sinkhole Claims

In 2006, the Legislature established an alternative process for resolving sinkhole disputes called "neutral evaluation." The Department of Financial Services (DFS) certifies engineers and geologists to serve as "neutral evaluators" of sinkhole claims disputes. If the parties do not reach a settlement, the neutral evaluator renders an opinion whether a sinkhole loss has been verified. Neutral evaluation must determine causation (whether a sinkhole loss has occurred and, if so, whether the observed damage was caused by sinkhole activity); all methods of stabilization and repair both above and below ground; the costs for stabilization and all repairs; and all information needed to determine whether a sinkhole loss has been verified and render an opinion on all matters at dispute in the neutral evaluation. Neutral evaluation is mandatory if requested by either party, but nonbinding, and the costs are paid by the insurer. The neutral evaluator's written recommendation is admissible in any subsequent action or proceeding relating to the claim.

Payment of Sinkhole Claims

If a covered building suffers a sinkhole loss or catastrophic ground cover collapse, the insured must repair such damage in accordance with the insurer's professional engineer's recommended repairs. However, if repairs cannot be completed within policy limits, the insurer has the option to either pay to complete the recommended repairs or tender policy limits. Payment shall be made to conduct such repairs in accordance with the recommendations of the professional engineer retained by the insurer under s. 627.707(2), F.S. The insurer may limit payment to the actual cash value of the sinkhole loss not including below-ground repair techniques until the policyholder enters into a contract for the performance of building stabilization repairs.

The two most commonly recommended stabilization techniques are grouting and underpinning. Under the grouting procedure, a grout mixture (composed of cement, sand, fly ash, and water) is injected into the ground to stabilize the subsurface soils to minimize further subsidence damage by increasing the density of the soils beneath the building as well as sealing the top of the limestone surface to minimize future raveling. Underpinning consists of steel pipes drilled or pushed into the ground to stabilize the building's foundation.

The contract for below-ground repairs to be made in accordance with the recommendations set forth in the insurer's sinkhole report issued pursuant to s. 627.7073, F.S., and entered into within 90 days after the policyholder receives notice that the insurer has confirmed coverage for sinkhole loss. The time period is tolled if either party invokes neutral evaluation. Stabilization and all other repairs to the structure and contents must be completed within 12 months after the policyholder enters into the contract for repairs unless the insurer and policyholder mutually agree otherwise, the claim is in litigation, or the claim is in neutral evaluation, appraisal or mediation.

Once building stabilization or foundation repairs of a sinkhole loss are completed, the professional engineer responsible for monitoring the repairs must issue a report to the property owner detailing the repairs performed and certifying that the repairs were performed properly. The professional engineer must file with the Clerk of Court a copy of the report and certification, the legal description of the real property, and the name of the county clerk of court.

Insurers who have paid a claim for sinkhole loss must file a copy of the engineer/geologist report, the neutral evaluator's report (if any), a copy of the certification indicating that stabilization has been completed (if applicable), the amount of the claim payment, and the legal description of the property with the county clerk, who must record the report and certification. The policyholder must file a copy of any sinkhole report prepared on behalf of the policyholder as a precondition to accepting a sinkhole loss payment. The seller of real property upon which a sinkhole claim has been made by the seller and paid by the insurer must disclose to the buyer that a claim has been paid and whether or not the full amount of proceeds were used to repair the sinkhole damage.

Limitation on Nonrenewal of Policy Due to Sinkhole Claims

An insurer may not nonrenew a policy due to the policyholder filing a sinkhole loss claim if the claim payments are less than policy limit for the covered building or if the policyholder repairs

the structure in accordance with the engineering recommendations that accompany sinkhole testing may only be nonrenewed if the insurer makes payments for sinkhole loss that equal or exceed policy limits for damage to the covered building or the policyholder does not repair the structure in accordance with the engineering recommendations.

III. Effect of Proposed Changes:

Section 1 amends s. 627.706(2)(k), F.S., to revise the definition of "structural damage" for purposes of determining if a sinkhole loss has occurred. The bill requires using the 2007 edition of the Florida Building Code to define when the interior building structure or members are unfit for service or represent a safety hazard as a result of interior floor displacement, thus constituting structural damage.

Section 2 amends s. 627.707, F.S., to changes the insurer's payment responsibility when a sinkhole loss is verified. The bill requires the insurer to "pay to stabilize the structure." Current law requires the insurer to pay, "to stabilize the land and building and repair the foundation." A policyholder who is paid by the insurer to stabilize the structure must also repair the sinkhole. The method used to stabilize the structure must be warranted for the lifetime of the structure.

The bill also requires an insurer to renew a property insurance policy if a claim for sinkhole loss is made and payments on the claim are less than the limits of coverage for property damage on the date of loss or if the policyholder repairs the structure in accordance with the engineering recommendations upon which any payment or policy proceeds were based.

Section 3 amends s. 627.7073, F.S., to specify that the sinkhole report and certification issued after testing by a professional engineer or professional geologist is the jointly owned property of the insurer and policyholder. The professional engineer or professional geologist who issued the report is required to send by certified mail, return receipt requested, two original signed and sealed reports to the policyholder and copy of the report to the insurer. The bill imposes a $25 per day penalty for each day that an insurer fails to file a copy of the sinkhole report and certification with the clerk of court within 30 days after paying a sinkhole claim. The penalty is payable to the clerk of court.

Section 4 provides an effective date of July 1, 2013.

Other Potential Implications:

The change in the insurer's payment responsibility may create ambiguities regarding the insurer's responsibilities for paying a sinkhole claim. Bill language requiring the insurer to pay to stabilize the structure, paired with the statement that "[a] policyholder who is paid by the insurer to stabilize the structure must also repair the sinkhole" may be interpreted to indicate that the insurer's duties are only to pay to stabilize the structure, and that the policyholder must pay out-of-pocket to repair the sinkhole (usually by injecting grout below ground). This ambiguity would occur when a sinkhole claims payment is made on the basis of a professional engineer's recommendation of grouting and underpinning after conducting sinkhole testing. The underpinning alone may serve to stabilize the structure; however, grouting would be required to repair the sinkhole activity.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires that the method used to stabilize the structure in a sinkhole repair must be warranted for the lifetime of the structure. It is uncertain whether vendors that perform such repairs currently provide such warranties.

The bill requires an insurer to renew a property insurance policy if a claim for sinkhole loss is made and claim payments are not greater than policy limits, or if the policyholder performs repairs in accordance with the engineering recommendations upon which any payment or policy proceeds were based. This may prevent an insurer from nonrenewing or cancelling an insurance policy for any reason other than nonpayment of premium.

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 Brandes

22-00706-13 20131498__

A bill to be entitled

An act relating to sinkhole insurance; amending s. 627.706, F.S.; revising the definition of the term "structural damage"; amending s. 627.707, F.S.; providing that an insurer must pay for stabilizing a structure if a sinkhole loss is verified, using a stabilization method that includes a specified type of warranty; requiring a policyholder who is paid by an insurer to stabilize a structure to repair the sinkhole; requiring an insurer to renew a property insurance policy when certain sinkhole losses have been paid; removing a provision authorizing an insurer to nonrenew a policy when the insurer has paid the policy limits for a sinkhole loss; amending s. 627.7073, F.S.; providing that a specified report to determine the presence or absence of sinkhole loss or other cause of damage is to be considered the jointly owned property of the insurer and the policyholder; requiring such reports to be provided to policyholders and insurers in a specified manner; providing requirements with respect to the form of such reports; specifying a period within which an insurer that pays a claim for sinkhole loss must file a copy of such report with the clerk of court; providing monetary penalty payable by the insurer to the clerk of court for failing to timely file such report; providing an effective date.

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

22-00706-13 20131498__

Section 1. Paragraph (k) of subsection (2) of section 627.706, Florida Statutes, is amended to read:

627.706 Sinkhole insurance; catastrophic ground cover collapse; definitions.—

(2) As used in ss. 627.706-627.7074, and as used in connection with any policy providing coverage for a catastrophic ground cover collapse or for sinkhole losses, the term:

(k) "Structural damage" means a covered building, regardless of the date of its construction, has experienced the following:

1. Interior floor displacement or deflection in excess of acceptable variances as defined in ACI 117-90 or the Florida Building Code, which results in settlement-related damage to the interior such that the interior building structure or members become unfit for service or represents a safety hazard as defined within the 2007 Florida Building Code;

2. Foundation displacement or deflection in excess of acceptable variances as defined in ACI 318-95 or the Florida Building Code, which results in settlement-related damage to the primary structural members or primary structural systems that prevents those members or systems from supporting the loads and forces they were designed to support to the extent that stresses in those primary structural members or primary structural systems exceeds one and one-third the nominal strength allowed under the Florida Building Code for new buildings of similar structure, purpose, or location;

3. Damage that results in listing, leaning, or buckling of the exterior load-bearing walls or other vertical primary

structural members to such an extent that a plumb line passing through the center of gravity does not fall inside the middle one-third of the base as defined within the Florida Building Code;

4. Damage that results in the building, or any portion of the building containing primary structural members or primary structural systems, being significantly likely to imminently collapse because of the movement or instability of the ground within the influence zone of the supporting ground within the sheer plane necessary for the purpose of supporting such building as defined within the Florida Building Code; or

5. Damage occurring on or after October 15, 2005, that qualifies as "substantial structural damage" as defined in the Florida Building Code.

Section 2. Subsections (5) and (7) of section 627.707, Florida Statutes, are amended to read:

627.707 Investigation of sinkhole claims; insurer payment; nonrenewals.—Upon receipt of a claim for a sinkhole loss to a covered building, an insurer must meet the following standards in investigating a claim:

(5) If a sinkhole loss is verified, the insurer shall pay to stabilize the structure ~~land and building and repair the foundation~~ in accordance with the recommendations of a ~~the~~ professional engineer retained pursuant to subsection (2), using a stabilization method that is warranted for the lifetime of the structure, with notice to the policyholder, subject to the coverage and terms of the policy. A policyholder who is paid by the insurer to stabilize the structure must also repair the sinkhole. The insurer shall pay for other repairs to the

structure and contents in accordance with the terms of the policy. If a covered building suffers a sinkhole loss or a catastrophic ground cover collapse, the insured must repair such damage or loss in accordance with the insurer's professional engineer's recommended repairs. However, if the insurer's professional engineer determines that the repair cannot be completed within policy limits, the insurer must pay to complete the repairs recommended by the insurer's professional engineer or tender the policy limits to the policyholder.

(a) The insurer may limit its total claims payment to the actual cash value of the sinkhole loss, which does not include underpinning or grouting or any other repair technique performed below the existing foundation of the building, until the policyholder enters into a contract for the performance of building stabilization or foundation repairs in accordance with the recommendations set forth in the insurer's report issued pursuant to s. 627.7073.

(b) In order to prevent additional damage to the building or structure, the policyholder must enter into a contract for the performance of building stabilization and foundation repairs within 90 days after the insurance company confirms coverage for the sinkhole loss and notifies the policyholder of such confirmation. This time period is tolled if either party invokes the neutral evaluation process, and begins again 10 days after the conclusion of the neutral evaluation process.

(c) After the policyholder enters into the contract for the performance of building stabilization and foundation repairs, the insurer shall pay the amounts necessary to begin and perform such repairs as the work is performed and the expenses are

incurred. The insurer may not require the policyholder to advance payment for such repairs. If repair covered by a personal lines residential property insurance policy has begun and the professional engineer selected or approved by the insurer determines that the repair cannot be completed within the policy limits, the insurer must complete the professional engineer's recommended repair or tender the policy limits to the policyholder without a reduction for the repair expenses incurred.

(d) The stabilization and all other repairs to the structure and contents must be completed within 12 months after entering into the contract for repairs described in paragraph (b) unless:

1. There is a mutual agreement between the insurer and the policyholder;

2. The claim is involved with the neutral evaluation process;

3. The claim is in litigation; or

4. The claim is under appraisal or mediation.

(e) Upon the insurer's obtaining the written approval of any lienholder, the insurer may make payment directly to the persons selected by the policyholder to perform the land and building stabilization and foundation repairs. The decision by the insurer to make payment to such persons does not hold the insurer liable for the work performed.

(f) The policyholder may not accept a rebate from any person performing the repairs specified in this section. If a policyholder receives a rebate, coverage is void and the policyholder must refund the amount of the rebate to the

insurer. Any person performing the repairs specified in this section who offers a rebate commits insurance fraud punishable as a third degree felony as provided in s. 775.082, s. 775.083, or s. 775.084. As used in this paragraph, the term "rebate" means a remuneration, payment, gift, discount, or transfer of any item of value to the policyholder by or on behalf of a person performing the repairs specified in this section as an incentive or inducement to obtain repairs performed by that person.

(7) An insurer shall renew ~~may not nonrenew~~ any policy of property insurance on the basis of filing of claims for sinkhole loss if the total of such payments does not equal or exceed the policy limits of coverage for the policy in effect on the date of loss, for property damage to the covered building, as set forth on the declarations page, or if the policyholder repaired the structure in accordance with the engineering recommendations made pursuant to subsection (2) upon which any payment or policy proceeds were based. ~~If the insurer pays such limits, it may nonrenew the policy.~~

Section 3. Section 627.7073, Florida Statutes, is amended to read:

627.7073 Sinkhole reports.—

(1) Upon completion of testing as provided in s. 627.7072, the professional engineer or professional geologist shall issue a report and certification, which shall be considered as property jointly owned by the insurer and the policyholder, to the insurer and the policyholder as provided in this section.

(a) Sinkhole loss is verified if, based upon tests performed in accordance with s. 627.7072, a professional

engineer or a professional geologist issues a written report and certification stating:

1. That structural damage to the covered building has been identified within a reasonable professional probability.

2. That the cause of the structural damage is sinkhole activity within a reasonable professional probability.

3. That the analyses conducted were of sufficient scope to identify sinkhole activity as the cause of damage within a reasonable professional probability.

4. A description of the tests performed.

5. A recommendation by the professional engineer of methods for stabilizing the land and building and for making repairs to the foundation.

(b) If there is no structural damage or if sinkhole activity is eliminated as the cause of such damage to the covered building, the professional engineer or professional geologist shall issue a written report and certification to the policyholder and the insurer stating:

1. That there is no structural damage or the cause of such damage is not sinkhole activity within a reasonable professional probability.

2. That the analyses and tests conducted were of sufficient scope to eliminate sinkhole activity as the cause of the structural damage within a reasonable professional probability.

3. A statement of the cause of the structural damage within a reasonable professional probability.

4. A description of the tests performed.

(c) The respective findings, opinions, and recommendations of the insurer's professional engineer or professional geologist

as to the cause of distress to the property and the findings, opinions, and recommendations of the insurer's professional engineer as to land and building stabilization and foundation repair set forth by s. 627.7072 shall be presumed correct.

(d) The professional engineer or professional geologist shall provide by certified mail, return receipt requested, two original signed and sealed reports to the policyholder and one photocopy of the report to the insurer.

(2) An insurer that has paid a claim for a sinkhole loss shall file a copy of the report and certification, prepared pursuant to subsection (1), including the legal description of the real property and the name of the property owner, the neutral evaluator's report, if any, which indicates that sinkhole activity caused the damage claimed, a copy of the certification indicating that stabilization has been completed, if applicable, and the amount of the payment, with the county clerk of court, who shall record the report and certification. The insurer shall bear the cost of filing and recording one or more reports and certifications. If an insurer fails to file a copy of the report within 30 days after payment of a sinkhole claim, a $25 penalty shall be assessed for each day beyond the 30th day that the insurer is determined to be in noncompliance with this section until the insurer is in compliance, which shall be payable to the clerk of the court. ~~There shall be no cause of action or liability against an insurer for compliance with this section.~~

(a) The recording of the report and certification does not:

1. Constitute a lien, encumbrance, or restriction on the title to the real property or constitute a defect in the title

to the real property;

2. Create any cause of action or liability against any grantor of the real property for breach of any warranty of good title or warranty against encumbrances; or

3. Create any cause of action or liability against any title insurer that insures the title to the real property.

(b) As a precondition to accepting payment for a sinkhole loss, the policyholder must file a copy of any sinkhole report regarding the insured property which was prepared on behalf or at the request of the policyholder. The policyholder shall bear the cost of filing and recording the sinkhole report. The recording of the report does not:

1. Constitute a lien, encumbrance, or restriction on the title to the real property or constitute a defect in the title to the real property;

2. Create any cause of action or liability against any grantor of the real property for breach of any warranty of good title or warranty against encumbrances; or

3. Create any cause of action or liability against a title insurer that insures the title to the real property.

(c) The seller of real property upon which a sinkhole claim has been made by the seller and paid by the insurer must disclose to the buyer of such property, before the closing, that a claim has been paid and whether or not the full amount of the proceeds was used to repair the sinkhole damage.

(3) Upon completion of any building stabilization or foundation repairs for a verified sinkhole loss, the professional engineer responsible for monitoring the repairs shall issue a report to the property owner which specifies what

repairs have been performed and certifies within a reasonable degree of professional probability that such repairs have been properly performed. The professional engineer issuing the report shall file a copy of the report and certification, which includes a legal description of the real property and the name of the property owner, with the county clerk of the court, who shall record the report and certification. This subsection does not create liability for an insurer based on any representation or certification by a professional engineer related to the stabilization or foundation repairs for the verified sinkhole loss.

Section 4. This act shall take effect July 1, 2013.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 418
INTRODUCER:	Senator Detert
SUBJECT:	Insurance
DATE:	April 6, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Burgess	BI	**Favorable**
2.			CM	
3.				
4.				
5.				
6.				

I. Summary:

SB 418 allows insurers to post insurance policies not containing policyholder personal identifiable information for certain types of insurance on the insurer's website instead of mailing or delivering the policy to the insured.

This bill substantially amends the following section of the Florida Statutes: 627.421.

II. Present Situation:

Section 627.421, F.S., requires every insurance policy[1] to be mailed or delivered to the insured (policyholder) within 60 days after the insurance takes effect. Insurance policies are typically only delivered when the policy is issued and are not delivered each time the policy is renewed.

The Federal Electronic Signatures in Global and National Commerce Act (E-SIGN)

The Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) applies to electronic transactions involving interstate commerce.[2] Insurance is specifically included in E-SIGN.[3] E-SIGN provides contracts formed using electronic signatures on electronic records will not be denied legal effect only because they are electronic. However, E-SIGN requires consumer

[1] s. 627.402, F.S., defines policy to include endorsements, riders, and clauses. Reinsurance, wet marine and transportation insurance, title insurance, and credit life or credit disability insurance policies do not have to be mailed or delivered. (see s. 627.401, F.S.)

[2] Section 101, Electronic Signatures in Global and National Commerce Act, Pub. L. no. 106-229, 114 Stat 464 (2000). Many of the provisions of E-SIGN took effective October 1, 2000.

[3] *Id.*

disclosure and consent to electronic records in certain instances before electronic records will be given legal effect. Under E-SIGN, if a statute requires information to be provided or made available to a consumer in writing, the use of an electronic record to provide or make the information available to the consumer will satisfy the statute's requirement of writing if the consumer affirmatively consents to use of an electronic record. The consumer must also be provided with a statement notifying the consumer of the right to have the electronic information made available in a paper format and of the right to withdraw consent to electronic records, among other notifications. Arguably, the affirmative consent and notification requirements of E-SIGN apply to the delivery of insurance policies in Florida because Florida law currently requires insurance policies to be delivered to the policyholder by mail or other delivery means.

Florida's Uniform Electronic Transaction Act (UETA)

Section 668.50, F.S., Florida's Uniform Electronic Transaction Act (UETA), is similar to the federal E-SIGN law. UETA specifically applies to insurance and provides a requirement in statute that information that must be delivered in writing to another person can be satisfied by delivering the information electronically if the parties have agreed to conduct a transaction by electronic means.

III. Effect of Proposed Changes:

The bill allows insurers to post insurance policies not containing policyholder personal identifiable information for certain types of insurance on the insurer's website instead of mailing or delivering the policy to the insured. Only policies for commercial motor vehicles, casualty insurance, and personal lines property insurance are allowed to be posted online. Commercial motor vehicle insurance policies are generally automobile policies covering vehicles used for occupational, professional, or business purposes. Casualty insurance includes automobile policies, workers' compensation policies, liability policies, and malpractice policies, among others.[4] Personal lines property insurance policies include homeowner's, tenant's, condominium unit owner's, and mobile home owner's property insurance policies.[5] The policy information posted online would be more general in nature. The policy declarations page which contains personal information about the policyholder and the policy would not be posted online and would be provided to the policyholder in another manner, usually by mail.

If an insurer opts to post an insurance policy online instead of mailing it, the policy must be easily accessible and posted in a format that allows the policy to be printed by the policyholder free of charge. Even for policies posted online, the insurer will deliver a policy declarations page to the policyholder setting out the specific coverage included in the policy. The declarations page must also identify the exact policy form purchased by the policyholder so the policyholder can find the policy on the insurer's website. Insurers posting policies on their website must notify each policyholder of their right to request and obtain a paper or electronic copy of the policy without charge, but policyholder consent is not required for an insurer to post an insurance policy online. Insurers must also notify policyholders of this right if the insurer changes a policy. Insurers posting policies online must archive expired policies for 5 years and archived policies must be available to policyholders at their request.

[4] s. 624.605, F.S.
[5] s. 627.4025(1), F.S.

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:

Insurers posting policies online will save costs associated with printing and mailing insurance policies to policyholders. The exact amount of savings cannot be calculated as it is unknown how many insurers will opt to post policies online and how many policyholders will choose to obtain their policies online rather than by mail.

Insurers may incur computer reprogramming costs associated with posting policies online and any increased costs will be passed through to policyholders.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill specifies it applies to commercial motor vehicle or personal lines property and casualty insurance. Commercial motor vehicle is a type of casualty insurance, thus, separately specifying the bill applies to commercial motor vehicle insurance is not needed.

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 Detert

28-00501-13 2013418__

A bill to be entitled

An act relating to insurance; amending s. 627.421, F.S.; authorizing the posting of specified types of insurance policies and endorsements on an insurer's Internet website in lieu of mailing or delivery to the insured if the insurer complies with certain conditions; providing an effective date.

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

Section 1. Section 627.421, Florida Statutes, is amended to read:

627.421 Delivery of policy.—

(1) Subject to the insurer's requirement as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto not later than 60 days after the effectuation of coverage.

(2) In the event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the

28-00501-13 2013418__

policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum. This subsection does not apply to inland marine floater policies.

(3) Any automobile liability or physical damage policy shall contain on the front page a summary of major coverages, conditions, exclusions, and limitations contained in that policy. Any such summary shall state that the issued policy should be referred to for the actual contractual governing provisions. The company may, in lieu of the summary, provide a readable policy.

(4) Notwithstanding subsections (1) and (2), commercial motor vehicle or personal lines property and casualty insurance policies and endorsements that do not contain personally identifiable information may be mailed, delivered, or posted on the insurer's Internet website. If the insurer elects to post insurance policies and endorsements on its Internet website in lieu of mailing or delivery to insureds, the insurer must comply with the following:

(a) Each policy and endorsement must be easily accessible for as long as the policy and endorsement remains in force.

(b) The insurer must archive all of its expired policies and endorsements and make any expired policy and endorsement available upon an insured's request for at least 5 years after expiration of the policy and endorsement.

(c) Each policy and endorsement must be posted in a manner that enables the insured to print and save the policy and

endorsement using a program or application that is widely available on the Internet without charge.

(d) When the insurer issues an initial policy form or any renewal form, the insurer must notify the insured, in the manner the insurer customarily uses to communicate with insureds, that the insured has the right to request and obtain without charge a paper or electronic copy of the insured's policy and endorsements.

(e) On each declarations page issued to the insured, the insurer must clearly identify the exact policy form and endorsement form purchased by the insured.

(f) If the insurer changes any policy form or endorsement, the insurer must notify the insured, in the manner the insurer customarily uses to communicate with insureds, that the insured has the right to request and obtain without charge a paper or electronic copy of such form or endorsement.

Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

Topic Insurance → web posting

Bill Number 418 *(if applicable)*

Name Doug Bell

Amendment Barcode *(if applicable)*

Job Title

Address 215 S. Monroe St *Street*

Tallahassee FL *City* *State* *Zip*

Phone 222-3533

E-mail

Speaking: ☒ For ☐ Against ☐ Information

Representing Progressive Ins.

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 Committee on Banking and Insurance

BILL: CS/SB 536

INTRODUCER: Health Policy Committee and Senator Detert

SUBJECT: Physical Therapy

DATE: April 5, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Fav/CS**
2.	Matiyow	Burgess	BI	**Favorable**
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 536 amends the definition of the practice of physical therapy by adding an advanced registered nurse practitioner (ARNP) to the practitioners who may authorize a physical therapist to implement a plan of treatment provided for a patient.

This bill substantially amends the following section of the Florida Statutes: 486.021.

II. Present Situation:

Physical Therapy Practice

Physical therapy includes assessment of the function of the musculoskeletal or neuromuscular system, including range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities and the treatment or rehabilitation of any disability, injury, disease, or other health condition of human beings. A variety of aids may be used in treatment or rehabilitation, including air, electricity, exercise, massage, acupuncture under certain conditions, radiant energy, ultrasound, water, and various apparatus and equipment.[1]

[1] *See* s. 486.021(10) and (11), F.S.

Physical therapists are licensed under ch. 486, F.S., the Physical Therapy Practice Act (the Act). A physical therapist is a person who is licensed and who practices physical therapy in accordance with the provisions of the Act. The Board of Physical Therapy Practice (Board) established within the Department of Health is responsible for implementing and administering the Act.

Currently, a physical therapist may implement a plan of treatment for a patient for up to 21 days for a condition not previously assessed by a practitioner of record. A practitioner of record may be a chiropractor, podiatrist, dentist, or a practitioner licensed under the medical practice act or osteopathic medical practice act. If treatment is needed beyond 21 days, the plan must be reviewed and signed by a practitioner of record.

A physical therapist is required to refer a patient to or consult with a practitioner of record if a patient's condition is found to be outside the scope of physical therapy. In addition, a physical therapist may not implement a plan of treatment for a patient who is currently being treated in a facility licensed pursuant to chapter 395 (hospital).[2]

Current statutes do not specifically authorize a physical therapist to implement a plan of treatment (accept a referral) provided by an ARNP, although it is within the ARNP's scope of practice to order physical therapy pursuant to a standing protocol with the supervising physician. Since 1998, at least three Declaratory Statements have been received and addressed by the Board relating to the ability of physical therapists to accept referrals from an ARNP or from a physician assistant. In two of the instances, the Board indicated that physical therapists could accept referrals from an ARNP as well as a physician assistant. In the third and most recent statement, the Board indicated that s. 486.021, F.S., did not provide for accepting referrals from an ARNP.[3]

Advanced Registered Nurse Practitioners (ARNP)

An ARNP is defined in s. 464.003, F.S., to be any person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners. An ARNP may perform acts of nursing diagnosis and nursing treatment of alterations of the health status. An ARNP may also perform acts of medical diagnosis and treatment, prescription, and operation which are identified and approved by a joint committee appointed by the Board.[4]

An ARNP may perform the following functions within the framework of an established protocol with a supervising physician which is filed with the Board:

- Monitor and alter drug therapies.
- Initiate appropriate therapies for certain conditions.
- Perform additional functions as determined by rule.

[2] *See* Department of Health Bill Analysis for SB 536 (dated January 24, 2013) on file with the Senate Health Policy Committee.
[3] Supra, fn 1
[4] s. 464.003(2), F.S.

- Order diagnostic tests, *physical therapy*, and occupational therapy.[5]

III. Effect of Proposed Changes:

Section 486.021, F.S., authorizes a physical therapist to implement a plan of treatment ordered by an ARNP as well as a practitioner of record.

The CS does not expand the scope of practice of an ARNP. It also does not designate an ARNP as a practitioner of record for purposes of referrals that a physical therapist must make if a patient's condition is found to be outside the scope of physical therapy or when physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record.

The CS restructures the definition of "practice of physical therapy" for clarity and makes other grammatical improvements.

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:

Physical therapists will be able to implement plans of treatment ordered by an ARNP. This will facilitate delivery of health care services in a more cost effective manner.

C. Government Sector Impact:

None.

[5] *See* s. 464.012(3), F.S.

VI. Technical Deficiencies:

None.

VII. Related Issues:

An ARNP is not added to the definition of practitioner of record, which perpetuates the limitation on an ARNP's otherwise lawful scope of practice with respect to ordering physical therapy.

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 Health Policy on March 7, 2013:
The CS reinstates the authority for a physical therapist to implement a plan of treatment after his or her own assessment and authorizes a physical therapist to implement a plan of treatment issued by an ARNP.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Detert

588-02016-13 2013536c1

A bill to be entitled

An act relating to physical therapy; amending s. 486.021, F.S.; authorizing physical therapists to implement physical therapy treatment plans of a specified duration which are provided by advanced registered nurse practitioners; providing an effective date.

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

Section 1. Subsection (11) of section 486.021, Florida Statutes, is amended to read:

486.021 Definitions.—In this chapter, unless the context otherwise requires, the term:

(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water; the use of apparatus and equipment in the application of the foregoing or related thereto; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography

588-02016-13 2013536c1

as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

(a) A physical therapist may implement a plan of treatment developed by the physical therapist for a patient or provided for a patient by a practitioner of record or by an advanced registered nurse practitioner licensed under s. 464.012. The physical therapist shall refer the patient to or consult with a ~~health care~~ practitioner of record ~~licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466,~~ if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record, the physical therapist shall obtain a practitioner of record who will review and sign the plan. For purposes of this paragraph, a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record.

(b) The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not ~~authorized under the term~~ "physical therapy" for purposes of ~~as used in~~ this chapter.

(c) The practice of physical therapy ~~as defined in this chapter~~ does not authorize a physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460.

(d) ~~Nothing in~~ This subsection does not authorize ~~authorizes~~ a physical therapist to implement a plan of treatment for a patient currently being treated in a facility licensed pursuant to chapter 395.

Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4-9-13
Meeting Date

Topic Relating to Physical Therapy Bill Number 536 *(if applicable)*

Name Allison Carvajal (CAR-VA-HALL) Amendment Barcode *(if applicable)*

Job Title Lobbyist

Address 120 S. Monroe St. Phone 850-727-7087
Street

Tallahassee FL. 32301 E-mail allison@carvajal-tally.com
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information Waive in Support

Representing Florida Nurse Practitioner 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)

4/1
Meeting Date

Topic _____ Bill Number 536 *(if applicable)*

Name Leslie Dughi Amendment Barcode _____ *(if applicable)*

Job Title _____

Address _____ Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Representing Associated Industries

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 Committee on Banking and Insurance

BILL:	SB 1006
INTRODUCER:	Senator Lee
SUBJECT:	Tax Credits or Refunds
DATE:	April 6, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Favorable**
2.			AFT	
3.			AP	
4.				
5.				
6.				

I. Summary:

SB 1006 would expand the availability of the bad debt tax credit or tax refund to "private-label" credit card or dealer credit programs. The bill would allow a dealer to take a tax credit or obtain a tax refund in situations where the dealer reported the tax, but another person, the lender, charges off the account or receivable with respect to a private-label credit card[1] or dealer credit program.

Current law requires dealers to collect and remit sales tax on the full sales price at the time of sale even if the sale is a credit card transaction or made pursuant to a deferred payment plan. Current law allows a dealer to take tax credit or seek a tax refund of any sales tax paid by the dealer on accounts that are determined to be worthless and that are charged off by the dealer as bad debts for federal income tax purposes. The dealer that paid the tax and charged off the account is the only person allowed to take the credit or claim the refund. In the case of private-label credit cards, the lender that issued the credit card may not take the credit or claim the refund for any amounts subsequently charged off by the lender.

This bill substantially amends the following section of the Florida Statutes: 212.17.

II. Present Situation:

The responsibilities of the Department of Revenue (DOR) include, but are not limited to, tax auditing activities, tax collection and enforcement, taxpayer assistance, and the development,

[1] Private label or store credit cards are cards branded for a specific retailer or independent dealer. If the retailer does not manage the private label card, a third-party issues the cards and collects the payments from cardholders.

maintenance, and management of information systems for tax return processing and taxpayer registration.[2]

The DOR is responsible for administering ch. 212, F.S., relating to the tax on sales, use, and other transactions. Under ch. 212, F.S., dealers are required to collect and remit sales tax on the full sales price at the time of sale, even if the transaction is a credit sale or made pursuant to a deferred payment plan.[3] A dealer who has paid the tax imposed under chapter 212, F.S., on tangible personal property or services may take a credit or obtain a refund for any tax paid by the dealer on the unpaid balance due on worthless accounts within 12 months following the month in which the bad debt has been charged off for federal income tax purposes. [4] The dealer that paid the tax and charged off the account is the only person allowed to take the credit or claim the refund. In the case of private-label credit cards, the lender that issued the credit card may not take the credit or claim the refund for any amounts subsequently charged off by the lender.

III. Effect of Proposed Changes:

Section 1 amends s. 212.17, F.S., by extending the availability of the bad debt credit or refund to private label credit card or dealer credit programs. With respect to the payment of taxes on purchases made through private-label credit card or dealer credit program, the bill requires that the following conditions be met before a deduction may be claimed or a refund obtained where consumer accounts or receivables are found to be worthless or uncollectable:

- The accounts or receivables have been charged off as bad debt on the lender's books and records on or after January 1, 2013;
- A credit was not previously claimed and a refund was not previously allowed on any portion of the accounts or receivables; and
- The credit or refund is claimed within 12 months after the month in which the bad debt is charged off by the lender for federal income tax purposes.

The section provides that only the dealer may claim the credit or obtain the refund. If a dealer or the lender subsequently collects the accounts or receivables for which a credit or refund has been granted, the dealer is required to pay tax on the "taxable percentage" of the amount collected for which a credit or refund was granted.

The section provides that the credit or refund allowed would include all credit-sale transaction amounts that are outstanding in the specific private-label credit card amount or receivable at the time the account or receivable is charged off.

A dealer's credit or refund for tax on bad debts may be claimed on any return filed by an entity that is related by direct or indirect common ownership of 50 percent or more.
A dealer may estimate the basis of the credit or refund by using one or the following methods:

- Applying an apportionment method using the dealer's "state and nonstate sales," the dealers taxable and nontaxable sales, and the amount of tax the dealer remitted to Florida; or

[2] Section 20.21, F.S.
[3] Section 212.06(1), F.S.
[4] Section 212.17(3), F.S.

- Applying a specified percentage of the accounts or receivables giving rise to the credit or refund. This percentage is derived from a sampling of the dealer's or lender's records in accordance with a methodology agreed upon by the DOR and the dealer.

The section creates definitions for various terms, including private-label credit card, and lender.

Section 2 provides that the act will take effect July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would extend the availability of the bad debt credit or refund to private-label credit card or dealer credit programs.

C. Government Sector Impact:

On March 16, 2013, the Revenue Estimating Conference adopted the following impact that assumed the low charge off rate, the middle recovery rate and updated growth rates from the March 15, 2013, General Revenue Conference. The summary information of the impact is provided below.

Tax: Sales and Use Tax
Issue: Refunds - Private Label Credit
Bill Number(s): HB 825/SB 1006

	General Revenue		Trust		Revenue Sharing		Local Half Cent	
	Cash	Recurring	Cash	Recurring	Cash	Recurring	Cash	Recurring
2013-14	(11.2)	(8.9)	(Insignificant)	(Insignificant)	(0.4)	(0.3)	(1.1)	(0.8)
2014-15	(9.7)	(9.2)	(Insignificant)	(Insignificant)	(0.3)	(0.3)	(0.9)	(0.9)
2015-16	(10.1)	(9.7)	(Insignificant)	(Insignificant)	(0.3)	(0.3)	(1.0)	(0.9)
2016-17	(10.6)	(10.1)	(Insignificant)	(Insignificant)	(0.4)	(0.3)	(1.0)	(1.0)
2017-18	(11.2)	(10.6)	(Insignificant)	(Insignificant)	(0.4)	(0.4)	(1.1)	(1.0)

	Local Option		Total Local		Total	
	Cash	Recurring	Cash	Recurring	Cash	Recurring
2013-14	(1.1)	(0.9)	(2.5)	(2.0)	(13.7)	(10.9)
2014-15	(0.9)	(0.9)	(2.2)	(2.1)	(11.9)	(11.3)
2015-16	(1.0)	(0.9)	(2.3)	(2.2)	(12.4)	(11.9)
2016-17	(1.0)	(1.0)	(2.4)	(2.3)	(13.0)	(12.4)
2017-18	(1.1)	(1.0)	(2.5)	(2.4)	(13.7)	(13.0)

VI. Technical Deficiencies:

The DOR identified the following issues with respect to the bill:

- Page 3, lines 68-69 -- provides that the revised subsection (4) applies "if consumer accounts or receivables are found to be worthless or *uncollectible*…" Existing s. 212.17(3), F.S., currently uses the term, "worthless." It is unclear if the bill language "or uncollectible" is superfluous or whether the bill intends to create a distinct standard under subsection (4).
- Page 4, lines 92-103 -- provides that a dealer may use one or two allowable methods for estimating the credit or refund amount. The first of the two proposed methods requires using, among other things, "the dealer's state and *nonstate* sales." For purposes of clarity, it is recommended that this language be changed to "dealer's Florida and non-Florida sales."
- Page 4, lines 108-110 -- provides that a dealer's deduction or credit may be claimed on any return filed by an entity related by direct or indirect common ownership of at least 50 percent. This provision may prove burdensome on the dealers and lenders involved, as well as the DOR, because the DOR will be required to trace all transfers of the debt, determine ownership interests, etc., when verifying a claim. In order to do so, the DOR will have to audit, and request documentation from all parties involved.
- Pages 4 -5, lines 116-199 -- define the term, "dealer credit," as "program arrangements where credit is extended for a specific purchase from a dealer. The term does not include arrangements for purchases of titled property." Although unclear, it appears the term, "dealer credit," relates to credit extended by a dealer, as opposed to by a lender. Assuming this is the case, any reference to "dealer credit" is unnecessary because s. 212.17(3), F.S., currently addresses bad debts involving credit provided by a dealer.
- Page 5, lines 120 - 134 -- In the definition of "lender," it is unclear what the following language means in proposed section 212.17(4)(g)[3.a.], F.S.: "or transferred from a third

party." (*see* page 5, lines 124 - 126). This analysis assumes the referenced language means that any third party transferee of an account or receivable is included in the definition of "lender." This assumption is consistent with the following language found later in the same definition of "lender": "or an assignee or other transferee of such person." (see page 5, lines 133 - 134). In cases where an account or receivable is transferred a number of times, the cases may prove to be burdensome on the parties to the various transactions, as well as on the DOR, because the DOR will be required to trace all transfers of the debt, determine ownership, etc., when verifying a claim. In order to do so, the DOR will have to audit, and request documentation from, all parties involved in the various transactions.

- Page 5, lines 120 - 134 – The term "lender" is defined to include, among other things, certain persons who own "*an interest* in a private-label credit card receivable or dealer credit receivable." (emphasis added) (see page 5, lines 120 - 123). It is conceivable that there could be multiple "lenders" owning an interest in the same receivable. These cases may prove to be burdensome on the parties to the various transactions, as well as on the DOR, because the DOR will be required to trace all transfers of the debt, determine ownership interests, etc., when verifying a claim. In order to do so, the DOR will have to audit, and request documentation from, all parties involved in the various transactions. Also, it is unclear what the proper credit or refund amount would be in these cases, particularly if only one lender charges off its "interest" in the receivable, given the following language in proposed section 212.17(4)(c), F.S.: "The credit or refund allowed includes *all credit sale transaction amounts* that are outstanding in the specific private-label credit card account or receivable at the time the account or receivable is charged off …." (emphasis added) (see pages 3 - 4, lines 87 - 91).
- Page 5, lines 132 - 133, refers to "a person described in paragraph (1)(a) or paragraph (1)(b) …." It is noted that although existing subsection (1) of section 212.17, F.S., does currently contain both a paragraph (a) and paragraph (b), it does not appear that the bill intended to reference these two paragraphs in existing subsection (1). Instead, the context of the bill suggests that the references in page 5, lines 132 - 133 of the bill, were intended to be to "sub-subparagraph a. or sub-subparagraph b."
- Pages 5 - 6, lines 135 - 147 – The definition of "private-label credit card" includes "dual cards," which are defined, in part, as "cobranded credit cards that may also be used to make purchases from persons other than the dealer whose name or logo appears on the card or the dealer's affiliates or franchisees." The bill provides that, with respect to dual cards, any purchases from persons other than the dealer or the dealer's affiliates or franchisees are not eligible for the bad debt deduction or refund. In other words, written-off dual card accounts or receivables may be comprised of both eligible and ineligible purchases. The bill provides that "the sales receipts of the dealer and the dealer's affiliates or franchisees must be identifiable apart from any receipts reflecting sales by unrelated persons;" however, it is unclear how the DOR could administer deduction or refund claims with respect to dual card accounts, particularly in light of (i) the allowable methods of estimation set forth in proposed section 212.17(4)(d), F.S., which do not appear to contemplate information from the dealer's franchisees or affiliates, or from unrelated persons, and (ii) proposed section 212.17(4)(c), F.S., which provides that "[t]he credit or refund allowed includes *all credit sale transaction amounts that are outstanding* in the specific private-label credit card account or receivable at the time the account or receivable is charged off ….". These cases may also prove to be burdensome on the dealers and lenders involved, because the DOR will be required to trace all transfers of the debt, determine ownership interests, separate eligible and ineligible

purchases, etc., when verifying a claim. In order to do so, the DOR will have to audit, and request documentation from, all parties involved.

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 Lee

24-00299D-13 20131006__

A bill to be entitled

An act relating to tax credits or refunds; reordering and amending s. 212.17, F.S.; providing procedures, requirements, and calculation methodologies that allow dealers or lenders to obtain tax credits or refunds for taxes paid on worthless or uncollectable private-label credit card or dealer credit card program accounts or receivables; providing definitions; providing an effective date.

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

Section 1. Section 212.17, Florida Statutes, is reordered and amended to read:

212.17 Tax credits or refunds ~~for returned goods, rentals, or admissions; goods acquired for dealer's own use and subsequently resold; additional powers of department~~.—

(1)(a) If ~~In the event~~ purchases are returned to a dealer by the purchaser or consumer after the tax imposed by this chapter has been collected from or charged to the account of the consumer or user, the dealer is ~~shall be~~ entitled to reimbursement of the amount of tax collected or charged by the dealer, in the manner prescribed by the department.

(b) A registered dealer that purchases property for the dealer's own use, pays tax on acquisition, and sells the property subsequent to acquisition without ~~ever~~ having used the property is entitled to reimbursement, in the manner prescribed by the department, of the amount of tax paid on the property's acquisition.

24-00299D-13 20131006__

(c) If the tax has not been remitted by a dealer to the department, the dealer may deduct the same in submitting his or her return upon receipt of a signed statement by ~~of~~ the dealer as to the gross amount of such refunds during the period covered by the ~~said~~ signed statement, which may ~~period shall~~ not be longer than 90 days. The department shall issue to the dealer an official credit memorandum equal to the net amount remitted by the dealer for such tax collected or paid. Such memorandum shall be accepted by the department at full face value from the dealer to whom it is issued upon~~, in~~ the remittance of ~~for~~ subsequent taxes accrued under ~~the provisions of~~ this chapter. If a dealer has retired from business and ~~has~~ filed a final return, a refund of tax may be made if it can be established to the satisfaction of the department that the tax was not due.

(2) A dealer who has paid the tax imposed by this chapter on tangible personal property sold under a retained title, conditional sale, or similar contract, or under a contract where ~~wherein~~ the dealer retains a security interest in the property pursuant to chapter 679, may take credit or obtain a refund for the tax paid by the dealer on the unpaid balance due him or her when he or she repossesses the property, ~~(~~with or without judicial process,~~) the property~~ within 12 months after ~~following~~ the month in which the property was repossessed. If ~~When~~ such repossessed property is resold, the sale is subject in all respects to the tax imposed by this chapter.

(3) Except as provided under subsection (4), a dealer who has paid the tax imposed by this chapter on tangible personal property or services may take a credit or obtain a refund for any tax paid by the dealer on the unpaid balance due on

worthless accounts within 12 months after ~~following~~ the month in which the bad debt has been charged off for federal income tax purposes. If any accounts so charged off for which a credit or refund has been obtained are subsequently, ~~thereafter~~ in whole or in part, paid to the dealer, the amount so paid shall be included in the first return filed after such collection and the tax paid accordingly.

(4) With respect to the payment of taxes on purchases made through a private-label credit card or dealer credit program:

(a) If consumer accounts or receivables are found to be worthless or uncollectible, the dealer may claim a credit for, or obtain a refund of, the tax remitted by the dealer on the unpaid balance due if:

1. The accounts or receivables have been charged off as bad debt on the lender's books and records on or after January 1, 2013;

2. A credit was not previously claimed and a refund was not previously allowed on any portion of the accounts or receivables; and

3. The credit or refund is claimed within 12 months after the month in which the bad debt is charged off by the lender for federal income tax purposes.

(b) If the dealer or the lender subsequently collects, in whole or in part, the accounts or receivables for which a credit or refund has been granted under paragraph (a), the dealer must include the taxable percentage of the amount collected in the first return filed after the collection and pay the tax on the portion of that amount for which a credit or refund was granted.

(c) The credit or refund allowed includes all credit sale

transaction amounts that are outstanding in the specific private-label credit card account or receivable at the time the account or receivable is charged off, regardless of the date the credit sale transaction actually occurred.

(d) A dealer may use one of the following methods to determine the amount of the credit or refund:

1. An apportionment method to substantiate the amount of tax imposed under this chapter which is included in the bad debt to which the credit or refund applies. The method must use the dealer's state and nonstate sales, the dealer's taxable and nontaxable sales, and the amount of tax the dealer remitted to this state; or

2. A specified percentage of the accounts or receivables giving rise to the credit or refund, which is derived from a sampling of the dealer's or lender's records in accordance with a methodology agreed upon by the department and the dealer.

(e) For purposes of computing the credit or refund, payments on the accounts or receivables shall be allocated based on the terms and conditions of the contract between the dealer or lender and the consumer.

(f) A dealer's credit or refund for tax on bad debt may be claimed on any return filed by an entity related by a direct or indirect common ownership of 50 percent or more.

(g) For purposes of this subsection, the term:

1. "Dealer's affiliates" means an entity affiliated with the dealer under 26 U.S.C. s. 1504, or an entity that would be an affiliate under that section had the entity been a corporation.

2. "Dealer credit" means program arrangements where credit

is extended for a specific purchase from a dealer. The term does not include arrangements for purchases of titled property such as motor vehicles, vessels, or motor homes.

3. "Lender" means a person who owns or owned a private-label credit card account or a dealer credit account, or an interest in a private-label credit card receivable or dealer credit receivable that:

a. The person purchased directly from a dealer or its affiliates who remitted the tax imposed under this chapter or transferred from a third party;

b. The person originated pursuant to that person's contract with the dealer or its affiliates who remitted the tax imposed under this chapter; or

c. Is affiliated in the manner described under 26 U.S.C. s. 1504, regardless of whether the different entities are corporations, to a person described in paragraph (1)(a) or paragraph (1)(b), or an assignee or other transferee of such person.

4. "Private-label credit card" means a charge card or credit card that carries, refers to, or is branded with the name or logo of a dealer and can be used for purchases from the dealer whose name or logo appears on the card or for purchases from the dealer's affiliates or franchisees. The term includes dual cards, which are cobranded credit cards that may also be used to make purchases from persons other than the dealer whose name or logo appears on the card or the dealer's affiliates or franchisees. The sales receipts of the dealer and the dealer's affiliates or franchisees must be identifiable apart from any receipts reflecting sales by unrelated persons. This subsection

does not authorize any credits or refunds with respect to sales by such unrelated persons.

(6) ~~(4)~~ (a) The department shall design, prepare, print and furnish to all dealers, except dealers filing through electronic data interchange, or make available or prescribe to the dealers, all necessary forms for filing returns and instructions to ensure a full collection from dealers and an accounting for the taxes due. The~~, but~~ failure of a ~~any~~ dealer to secure such forms does not relieve the dealer from the payment of the tax at the time and in the manner provided.

(b) The department shall prescribe the format and instructions necessary for filing returns in a manner that is initiated through an electronic data interchange to ensure a full collection from dealers and an accounting for the taxes due. The failure of a ~~any~~ dealer to use such format does not relieve the dealer from the payment of the tax at the time and in the manner provided.

(7) ~~(5)~~ The department and its assistants are ~~hereby~~ authorized and empowered to administer the oath for the purpose of enforcing and administering ~~the provisions of~~ this chapter.

(8) ~~(6)~~ The department may ~~has authority to~~ adopt rules ~~pursuant to ss. 120.536(1) and 120.54~~ to administer and enforce ~~the provisions of~~ this section ~~chapter~~.

(5) ~~(7)~~ The department, where admissions, license fees, or rental payments or payments for services are made and ~~thereafter~~ returned to the payors after the taxes ~~thereon~~ have been paid, shall return or credit the taxpayer for taxes ~~so~~ paid on the moneys returned in the same manner as ~~is~~ provided for returns or credits of taxes where purchases or tangible personal property

are returnable to a dealer.

Section 2. This act shall take effect July 1, 2013.

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 Committee on Banking and Insurance

BILL:	CS/SB 1098
INTRODUCER:	Banking and Insurance Committee and Senator Richter
SUBJECT:	General Assignments
DATE:	April 9, 2013 REVISED:

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

Please see Section VIII. for Additional Information:

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

I. Summary:

CS/SB 1098 streamlines for the discharge of duties by an assignee under an assignment for the benefit of creditors. The changes to the law relating to an assignment for the benefit of creditors were recommended by the Business Law Section of The Florida Bar as part of its comprehensive review of the law.[1] This bill:

- Creates a negative notice procedure to allow an assignee when discharging duties under an assignment for the benefit of creditors to give notice to interested parties of a planned action. In the absence of objection, the assignee may proceed without a hearing. A form is created for providing negative notice of certain acts to be undertaken by the assignee.
- Sets a minimum bond for assignees under an assignment for the benefit of creditors of at least $25,000 or double the liquidation value of the unencumbered and liquid assets of the insolvent estate, whichever is higher.
- Authorizes an assignee to conduct discovery as provided for in the Florida Rules of Civil Procedure in the course of prosecuting or objecting to claims.

[1] *See*, The Business Law Section of The Florida Bar, *White Paper: Support for Proposed Amendments to Chapter 727, F.S., Assignments for the Benefit of Creditors* (on file with the Senate Committee on Judiciary).

- Eliminates a conflict in existing law relating to an extension of the time within which an assignee may conduct the business of an insolvent debtor to allow the assignee to conduct the business of the insolvent debtor for 45 days, or longer, if needed and appropriate notice is given.
- Identifies the parties entitled to notice and the contents of the notice when an assignee rejects a lease when discharging his or her duties for an insolvent estate.
- Creates a form for deeds for use by an assignee in the sale of real property by an insolvent estate.

This bill substantially amends the following sections of the Florida Statutes: 727.103, 727.104, 727.108, 727.109, 727.110, 727.111, and 727.113.

This bill creates section 727.117, Florida Statutes.

II. Present Situation:

The practice of assignment for the benefit of creditors is a state law procedure to administer an insolvent estate. Under an assignment for the benefit of a creditor, a debtor may voluntarily assign its assets to a third party.[2] The practice of assignment for the benefit of creditors involves an assignment in which the debtor voluntarily assigns its assets to a third party as a trustee for the purpose of liquidating the assets to satisfy, in full or in part, creditors' claims against the debtor.[3]

The practice of assignment for the benefit of creditors existed at common law and was codified in Florida law in 1889.[4] Florida law codifying the practice of assignment for the benefit of creditors was substantially re-drafted and codified in ch. 727, F.S.[5]

Under Florida law,[6] an assignment for the benefit of creditors "accomplishes the same result as a [federal] bankruptcy."[7] An assignment for the benefit of creditors is similar to federal bankruptcy proceedings by allowing the liquidation of a debtor's property for an equal distribution to creditors.[8] An assignment to the benefit of creditors may be distinguished from a federal bankruptcy proceeding in that it does not impose an automatic stay of collection efforts in favor of the debtor and the debtor is not discharged from his or her debt.[9]

An assignment for the benefit of creditors under ch. 727, F.S., commences with an assignment proceeding in which the insolvent debtor (assignor)[10] executes an irrevocable assignment in

[2] *See, id.*
[3] *See Moecker v. Antoine*, 845 So. 2d 904, 910 (Fla. 1st DCA 2003) (citing *Brainard v. Fitzgerald*, 3 Cal.2d 157, 44 P.2d 336, 339 (Cal. 1935)). *See also*, The Business Law Section of The Florida Bar, *supra* note 1.
[4] *Moecker*, 845 So. 2d at 910.
[5] *See generally*, chapter 3891, Laws of Florida and substantial redrafting with the enactment of ch. 87-174, ss. 1-17, Laws of Florida.
[6] See ch. 727, F.S.
[7] Henry P. Trawick, Jr., *Trawick's Florida Practice and Procedure*, s. 37:18 (2012 ed.).
[8] *See also*, The Business Law Section of The Florida Bar, *supra* note 1.
[9] *Id.*
[10] "Assignor" means one who transfers property rights or powers to another. BLACK'S LAW DICTIONARY (9th ed. 2009).

writing in compliance with a statutory form.[11] Then, the original assignment must be recorded in the county where the assignor had its principal place of business and a certified copy recorded in each county where assets of the assignor's estate are located.[12] The assignee[13] must file a petition with the clerk of the court to commence an assignment proceeding, and then file a motion requesting the court to fix the appropriate amount of the assignee's bond.[14] The amount of the bond may not be less than double the liquidation value of the assets and is conditioned upon the assignee's discharge of the duties.[15]

Practitioners have stated that a need exists for more consistency and guidance in the procedures used to handle an assignment for the benefit of creditors.

III. Effect of Proposed Changes:

Negative Notice

The bill creates a new procedure for use with an assignment for the benefit of creditors. The purpose of the procedure is to reduce the administrative burden on courts and the administrative costs to the estate for hearings for relief that are not contested or opposed.[16] "Negative notice is a common procedural tool in federal bankruptcy court."[17] Under the bill, notice may be served by negative notice by including a specific form warning in the document (as set forth in s. 727.114(4), F.S., that:

- The assignee proposes to take certain actions described in the notice without further notice or hearing unless a party in interest files an objection within 21 days of service of the notice;
- Any objection to the notice must be filed with the clerk of the court and served on the assignee's attorney and any other appropriate person;
- If an objection is filed and served within the time permitted, the court must schedule a hearing; and
- If no objection is filed, the assignee and the court will presume that no party opposes the granting of the relief requested in the notice.

If an objection is not filed within the time prescribed, the assignee may take the actions described in the notice.[18]

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[11] *See* Ronald G. Neiwirth and Jason Bloom, *Florida Legislature Overhauls Assignment for the Benefit of Creditors: More Similar to Bankruptcy, But With a Twist*, 82 FLA. B.J. 20, 20 (Jan. 2008) and s. 727.104(1)(a), F.S.
[12] *Id.* at 20 and s. 727.104(2)(a), F.S.
[13] "Assignee" means one to whom property rights or powers are transferred by another. BLACK'S LAW DICTIONARY (9th ed. 2009).
[14] *See* Ronald G. Neiwirth and Jason Bloom, *supra* note 11 at 20 and s. 727.104(2)(b), F.S.
[15] "The assignee must accept the trust created by the assignment and agree to carry it out as provided by law without delay." See Henry P. Trawick, Jr., *supra* note 6 and s. 727.104(1), F.S.
[16] *See* The Business Law Section of The Florida Bar, *supra* note 1.
[17] *See* Ronald G. Neiwirth and Jason Bloom, *supra* note 11 at 26 (citing Local Rule 9013-1(D) of the U.S. Bankruptcy Court for the Southern District of Florida which generally explains that "certain motions may be considered by the court without a hearing if appropriate notice and an opportunity to object to the relief requested is provided to interested parties ("negative notice")).")
[18] Under s. 727.111(4), F.S., the actions include: a proposed sale of assets of the estate other than in the ordinary course of business, the assignee's continued operation of the assignor's (insolvent debtor's) business for longer than 45 calendar days,

Notice

A subtle conflict currently exists between s. 727.108(4), F.S., which allows an assignee to conduct the business of the assignor for up to 14 days (or longer upon notice), and s. 727.111(4), F.S., which requires not less than 20 days' notice of an assignee's continued operation of the assignor's business for longer than 14 calendar days. Thus, an assignee's compliance with both provisions is impossible unless the notice required by s. 727.111(4), F.S., is sent before the assignment has occurred.

To remedy the conflict, the bill provides an extension of the time within which an assignee may conduct the business of the assignor under s. 727.108(4), F.S., from 14 days to 45 days. The additional time is a larger window within which an assignee can assess the business, determine a strategy for liquidation, and, if necessary, give notice of intent to operate the business for an additional period. The assignee may continue to operate the business for up to 90 days if there is no objection to a negative notice given to interested parties. This period may also be extended. The bill leaves intact the condition that such operation of the business must be in the best interest of the estate.

Notice to Creditors

Currently, s. 727.111, F.S., requires a notice to be mailed at least 20 days before a proposed sale of assets, the payment of fees, or the settlement of a case, which might be an asset of the estate. To streamline the deadlines set forth in the statute into multiples of 7 days, the bill extends the minimum amount of time for notice under the statute from 20 days to 21 days.

Assignee Bond

The purpose of the bond under an assignment for the benefit of creditors is to "protect the assignor's creditors from potential loss in the event of the assignee's improper and irreparable disposition of the assignor's assets."[19] Under current law, courts must set the bond in an amount not less than double the liquidation value of the assets of the estate. This requirement has led some courts to impose an unnecessarily high bond requirement, which adds costs to the administration of an insolvent estate under assignment for the benefit of creditors.[20] The bill amends s. 727.104(4), F.S., to revise the assignee's bond requirement to be at least $25,000 or double the liquidation value of the unencumbered and liquid assets of the estate, whichever is higher. The amendment will have the effect of requiring a minimum bond amount without artificially inflating the bond amount based on a large amount of secured or unliquidated debt.

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the compromise or settlement of a controversy, and the payment of fees and expenses to the assignee and to professional persons employed by the assignee.

[19] The Business Law Section of The Florida Bar, *supra* note 1 (citing *Williamson v. Leith*, 36 F.2d 643, 644 (Fla. 5th DCA 1929)).

[20] *Id.*

Objections to Claims

In an assignment for the benefit of creditors, creditors of an assignor file claims with the assignee who is charged with determining the validity and priority of such claims before distributing the assignor's assets in accordance with statutory requirements.[21] The assignee or any other party in interest may object to a creditor's claim.[22] The bill adds procedural amendments to s. 727.113(1), F.S., to specify which parties are entitled to service of any such objection and the service address of the claimant for objections to claims. This provision is also subject to the negative notice procedure created in the bill.

Assignee's Deed

The bill creates s. 727.117, F.S., adding a form deed to statutory provisions for an assignment for the benefit of creditors. The deed is in substantially the same form as the warranty deed set forth in s. 689.02, F.S., without the warranties of title. Instead, the assignee states that the grantor executes the instrument in its capacity as assignee of the estate of the insolvent debtor. The deed also states that the assignee is not personally liable because of the instrument.

Rejection of Unexpired Leases

The statute currently allows an assignee to reject an unexpired lease of non-residential real property or personal property.[23] However, it provides little guidance regarding the proper procedure for such rejection.[24] In the interest of establishing consistent practices, the bill revises s. 727.110, F.S., to codify the procedure for such rejection.

The bill specifies:

- The parties entitled to notice of the rejection;
- The information that must be included in the notice of such rejection; and
- The effective date of the rejection.

The bill also confirms the termination of an estate's rights, obligations, and liability concerning the leased property if a lessor fails to take possession upon rejection. The bill also authorizes an as assignee to use the negative notice procedure for the notice of rejection.

Discovery

The Business Law Section of The Florida Bar has indicated that disputes have arisen among practitioners regarding the applicability of the discovery provisions in the Florida Rules of Civil Procedure to cases involving the discharge of an assignee's statutory duties to:

[21] Section 727.113, F.S.
[22] Section 727.113(3), F.S.
[23] See ss. 727.108(5) and 727.109(6), F.S.
[24] The Business Law Section of The Florida Bar, *supra* note 1.

- Determine whether to prosecute estate claims and causes of action;[25]
- Examine the validity and priority of claims against the estate;[26] and
- Investigate the value or benefits of an asset of the estate.[27]

The bill amends s. 727.108(1)(a), F.S., and s. 727.113, F.S., to confirm an assignee's right to conduct discovery as provided in the Florida Rules of Civil Procedure in the discharge of the assignee's duty to determine whether to prosecute such claims or causes of actions; and concerning objections to claims in all cases pending on July 1, 2013, or filed thereafter.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

To the extent that the bill reduces costs associated with assignments for the benefit of creditors, additional funds will be available to pay creditor claims.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

[25] Section 727.108(1)(a), F.S.
[26] Section 727.108(10), F.S.
[27] Section 727.108(11), F.S.

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 April 9, 2013
The CS amends the deed form to include the parcel identification number of real property transferred; and clarifies that the assignee's deed form provided in the bill is to be used to transfer real property.

B. Amendments:

None.

264374

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 282
and insert:
727.117 Assignee's deed form.—
(1) If an assignee sells real property

836278

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment

Between lines 366 and 367
insert:

(2) The form for an assignee's deed shall include a blank space for the property appraiser's parcel identification number describing the property conveyed, which number, if available, shall be entered on the deed before it is presented for recording. The failure to include such blank space or the parcel identification number, or the inclusion of an incorrect parcel identification number, does not affect the validity of the conveyance or the recordability of the deed. Such parcel

836278

identification number is not a part of the legal description of the property otherwise set forth in the deed and may not be used as a substitute for the legal description of the property being conveyed.

By Senator Richter

23-00725A-13 20131098__

A bill to be entitled

An act relating to general assignments; amending s. 727.103, F.S.; defining the term "negative notice"; amending s. 727.104, F.S.; requiring an assignee's bond to be in at least a specific amount or double the liquidation value of the unencumbered and liquid assets of the estate, whichever is higher; amending s. 727.108, F.S.; authorizing an assignee to conduct certain discovery to determine whether to prosecute certain claims or causes of action; extending the time period an assignee may conduct the business of the assignor; authorizing the assignee to continue conducting the business of the assignor under certain circumstances by serving negative notice; amending s. 727.109, F.S.; extending the time period for which a court may authorize an assignee to conduct the business of the assignor; amending s. 727.110, F.S.; providing procedures for an assignee's rejection of an unexpired lease of nonresidential real property or of personal property; requiring the assignee to serve a notice of rejection on certain persons and file it with the court; requiring that a notice of rejection for personal property include certain information about the affected property; specifying the effective date of the rejection; requiring the estate's rights and obligations to and liability for the affected property to terminate under certain circumstances; amending s. 727.111, F.S.; extending the minimum time period for giving notice to the assignor and

23-00725A-13 20131098__

creditors; conforming language; providing a procedure for serving notice on certain persons; requiring an objection to be filed and served within a specific time period; requiring the notice to be in a specified form; providing that the assignee may take certain actions if an objection is not filed; requiring the court to hear a filed objection; authorizing the court to shorten negative notice under certain circumstances; providing that a party may raise the shortened notice period in certain objections; requiring a certificate of service for negative notice to be filed with the court under certain circumstances; requiring negative notice to be given to certain persons under certain circumstances; amending s. 727.113, F.S.; providing procedures for serving an objection to a claim; providing that the Florida Rules of Civil Procedure apply to objections to claims in all pending cases beginning on a specific date; creating s. 727.117, F.S.; requiring an assignee's deed to be in a specific form; providing an effective date.

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

Section 1. Present subsection (13) of section 727.103, Florida Statutes, is redesignated as subsection (14), and a new subsection (13) is added to that section, to read:

727.103 Definitions.—As used in this chapter, unless the context requires a different meaning, the term:

(13) "Negative notice" means notice as set forth in s. 727.111(4) which, unless a response is filed within 21 days after the date of service thereof, allows certain actions set forth in the notice to occur.

Section 2. Subsection (2) of section 727.104, Florida Statutes, is amended to read:

727.104 Commencement of proceedings.—

(2) Within 10 days after delivery of the assignment to the assignee, the assignee shall:

(a) Record the original assignment in the public records of the county in which the assignor had its principal place of business and shall thereafter promptly record a certified copy of the assignment in each county where assets of the estate are located.~~;~~

(b) File, in the office of the clerk of the court in the county of the assignor's place of business if it has one, in the county of its chief executive office if it has more than one place of business, or in the county of the assignor's residence if the assignor is an individual not engaged in business, in accordance with the procedures for filing a complaint as set forth in the Florida Rules of Civil Procedure, a petition setting forth the name and address of the assignor and the name and address of the assignee; a copy of the assignment, together with Schedules A and B; and a request that the court fix the amount of the assignee's bond to be filed with the clerk of the court. This bond is ~~shall be~~ subject to reconsideration upon the motion of any party in interest after notice and hearing. The bond is ~~shall be~~ payable to the clerk of the court, in an amount not less than $25,000 or double the liquidation value of the

unencumbered and liquid assets of the estate as set forth in Schedule B, whichever is higher, conditioned upon the assignee's faithful discharge of her or his duties. Within 30 days after the court enters an order setting the amount of such bond, the assignee shall file the bond with the clerk of the court, who shall approve the bond.

Section 3. Subsections (1) and (4) of section 727.108, Florida Statutes, are amended to read:

727.108 Duties of assignee.—The assignee shall:

(1) Collect and reduce to money the assets of the estate, whether by suit in any court of competent jurisdiction or by public or private sale, including, but not limited to, prosecuting any tort claims or causes of action that ~~which~~ were previously held by the assignor, regardless of any generally applicable law concerning the nonassignability of tort claims or causes of action.~~; and;~~

(a) With respect to the estate's claims and causes of action, the assignee may:

1. Conduct discovery as provided under the Florida Rules of Civil Procedure to determine whether to prosecute such claims or causes of actions.

2. Prosecute such claims or causes of action as provided in this section. ~~or~~

3. Sell and assign, in whole or in part, such claims or causes of action to another person or entity on the terms that the assignee determines are in the best interest of the estate under ~~to~~ s. 727.111(4).~~; and~~

(b) In an action in any court by the assignee or the first immediate transferee of the assignee, other than an affiliate or

insider of the assignor, against a defendant to assert a claim or chose in action of the estate, the claim is not subject to, and any remedy may not be limited by, a defense based on the assignor's acquiescence, cooperation, or participation in the wrongful act by the defendant which forms the basis of the claim or chose in action.

(4) Conduct the business of the assignor for a limited period ~~that may~~ not to exceed 45 ~~14~~ calendar days, if doing so is in the best interest of the estate, or for a longer period if~~,~~ in the best interest of the estate, upon notice and until such time as an objection, if any, is sustained by the court~~; however, the assignee may not operate the business of the assignor for longer than 45 calendar days without a court order authorizing such operation if an objection by a party in interest is interposed to the assignee's motion for authority to operate the assignor's business~~. An assignee's authorization to conduct the business of the assignor may be extended for a period longer than 45 days upon service of negative notice. If no timely objection is filed with the court, the assignee may continue to operate the assignor's business for an additional 90 days. The court may extend the 90-day period if it finds an extension to be in the best interest of the estate.

Section 4. Subsection (3) of section 727.109, Florida Statutes, is amended to read:

727.109 Power of the court.—The court shall have power to:

(3) Upon notice and a hearing, if requested, authorize the business of the assignor to be conducted by the assignee for longer than 45 ~~14~~ calendar days, if in the best interest of the estate.

Section 5. Subsection (3) is added to section 727.110, Florida Statutes, to read:

727.110 Actions by assignee and other parties in interest.—

(3) As to an assignee's rejection of an unexpired lease of nonresidential real property or of personal property, as provided under ss. 727.108(5) and 727.109(6):

(a) The assignee shall file a notice of rejection with the court and serve a copy on the owner or lessor of the affected property and, for personal property, on the landlord of the premises on which the property is located. A notice of rejection relating to personal property must identify the affected property, the address at which the affected property is located, the name and telephone number of the person in possession of the affected property, and the deadline for removal of the affected property.

(b) The effective date of the rejection is the date of entry of a court order authorizing such rejection.

(c) If the lessor of the affected property fails to take possession thereof after notice of the rejection, the estate's rights and obligations to and liability for the property terminate upon the effective date of the rejection.

Section 6. Subsections (4), (6), and (8) of section 727.111, Florida Statutes, are amended to read:

727.111 Notice.—

(4) The assignee shall give the assignor and all creditors at least ~~not less than~~ 21 ~~20~~ days' notice by mail of a proposed sale of assets of the estate other than in the ordinary course of business, the assignee's continued operation of the assignor's business for longer than 45 ~~14~~ calendar days, the

compromise or settlement of a controversy, and the payment of fees and expenses to the assignee and to professional persons employed by the assignee pursuant to s. 727.108(7). The notice shall be served on all creditors and their attorneys, if any, at the address provided in the creditor's proof of claim. If a proof of claim has not been filed by a creditor that is registered to do business in this state, the notice must be served on the creditor's registered agent as listed with the Division of Corporations of the Department of State and on the creditor's attorney, if known. If a proof of claim has not been filed and the creditor does not have a registered agent within the state, the notice must be served on the creditor at the address listed in the schedules filed by the assignor. Objection ~~Any objections~~ to the proposed action must be filed and served upon the assignee and the assignee's attorney, if any, within 21 days after service of the notice ~~not less than 3 days before the date of the proposed action~~. The notice shall be in the following form: ~~must include a description of the proposed action to be taken, the date of the proposed action, and the date and place for the hearing at which any objections will be heard.~~

NOTICE OF OPPORTUNITY TO OBJECT AND REQUEST A HEARING

IN THE CIRCUIT COURT
OF THE ....
CIRCUIT, IN AND FOR
.... COUNTY,
FLORIDA

IN RE:.....,
Assignor,
TO:.....,
Assignee.

TO CREDITORS AND OTHER INTERESTED PARTIES:

PLEASE TAKE NOTICE that, pursuant to s. 727.111(4), Florida Statutes, the assignee may ...(List applicable action(s) described in s. 727.111(4))..., and the Court may consider these actions without further notice or hearing unless a party in interest files an objection within 21 days from the date this paper is served. If you object to the relief requested in this paper, you must file your objection with the Clerk of the Court at...(Clerk's address)..., and serve a copy on the assignee's attorney,...(attorney's name and address)..., and any other appropriate person.

If you file and serve an objection within the time permitted, the Court shall schedule a hearing and notify you of the scheduled hearing. If a hearing is already scheduled, list the date, time, and location of the hearing: ...(date, time, and location)...

If you do not file an objection within the time permitted, the assignee and the Court will presume that you do not oppose the granting of the relief requested in the paper.

.....

ASSIGNEE

Attorney for assignee (if any):.....

Address:.....

If no objections are ~~not~~ timely filed and served, the assignee may take such action as described in the notice without further order of the court or may obtain an order approving the action without further notice or hearing ~~of the court granting such motion if the assignee reasonably believes that the order is necessary to proceed with the action contemplated by the motion~~. If an objection is filed, the court shall hold a hearing on the objection.

(6) For good cause shown and without notice of hearing, the court may shorten the notice or negative notice period or limit the parties to whom notice or negative notice need be given, pursuant to subsection (3) or subsection (4). This subsection does not affect the right of a party in interest to raise the shortened notice period in any objection to the relief sought under subsection (4).

(8) Wherever notice or negative notice is required to be given under this chapter, a certificate of service of such notice or negative notice shall be filed with the court, and notice or negative notice shall be given to all consensual lienholders and counsel who have filed a notice of appearance with the court or who are identified in the assignor's schedules.

Section 7. Subsection (1) of section 727.113, Florida Statutes, is amended, and subsection (5) is added to that

section, to read:

727.113 Objections to claims.—

(1) At any time before ~~prior to~~ the entry of an order approving the assignee's final report, the assignee or any party in interest~~, including another creditor of the assignor,~~ may file with the court an objection to a claim, which objection must be in writing and set forth the nature of the objection, and shall serve a copy thereof on the creditor at the address provided in the proof of claim, and to the assignee and the assignee's attorney, if any. The objection may be served on negative notice. ~~A copy of the objection, together with notice of hearing thereon, shall be mailed to the creditor at least 20 days prior to the hearing.~~ All claims properly filed with the assignee and not disallowed by the court constitute all claims entitled to distribution from the estate.

(5) The discovery provisions of the Florida Rules of Civil Procedure apply to objections to claims in all cases pending on July 1, 2013, or filed thereafter.

Section 8. Section 727.117, Florida Statutes, is created to read:

727.117 Assignee's deed form.—If an assignee sells property of the estate, the deed shall be in substantially the following form:

ASSIGNEE'S DEED

This Assignee's Deed is made and executed this .... day of ...., ...(year)..., by ...., as Assignee for the Estate of ...., Case No. .... in the Circuit Court of .... County, Florida,

whose post office address is .... (hereinafter "Grantor"), to ...., whose post office address is .... (hereinafter "Grantee").

Wherever used herein, the terms "Grantor" and "Grantee" include all the parties to this instrument, singular and plural, and the heirs, legal representatives, and assigns of these individuals, and the successors and assigns of corporations, wherever the context so admits or requires.

WITNESSETH:

That Grantor, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration in hand paid to said Grantor by Grantee, the receipt of which is hereby acknowledged, hereby grants, bargains, sells, aliens, remises, releases, conveys, and confirms unto Grantee, all of that certain real property lying and being in the County of ...., State of Florida, more particularly described as follows:

SEE ATTACHED "EXHIBIT A," which is incorporated herein by the term "Property".

This conveyance is subject to taxes accruing for the year of conveyance and subsequent years, and all encumbrances, covenants, conditions, and restrictions of record, except nothing herein operates to reimpose same.

TOGETHER with all the tenements, hereditaments, and appurtenances thereto belonging or in anywise appertaining.

TO HAVE AND TO HOLD the same in fee simple forever.

AND the Grantor hereby covenants with said Grantee that Grantor has good right and lawful authority to sell and convey said Property.

Grantor executed this instrument only in Grantor's capacity as Assignee of the above referenced Assignment estate and no personal judgment shall ever be sought or obtained against Grantor individually by reason of this instrument.

IN WITNESS WHEREOF, said Grantor has caused these presents to be executed the day and year first written above.

GRANTOR:

...(Grantor's Signature)...
Print Name:.....
As Assignee for the Estate of ...(Assignor's Name)...
Case No. ....
Circuit Court of .... County, Florida

Signed, sealed and delivered
in the presence of:

...(Witness's Signature)...
Witness
...(Witness's Name Printed)...
Print Name

...Witness's Signature...
Witness
...(Witness's Name Printed)...
Print Name

STATE OF FLORIDA
COUNTY OF ....

Sworn to and subscribed before me this .... day of ....,
...(year)..., by ...(Assignee's Name)..., as Assignee for the
Estate of ...(Assignor's Name)..., Case No. ...., Circuit Court
of .... County, Florida, on behalf of said estate.

...(Signature of Notary Public - State of Florida)...
...(Print, Type, or Stamp Commissioned Name of Notary Public)...
Personally Known .... OR Produced Identification ....
Type of Identification Produced:....

Section 9. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/9/13
Meeting Date

Topic Assignments for the Benefit of Creditors Bill Number SB 1098 *(if applicable)*

Name Greg Black Amendment Barcode _____ *(if applicable)*

Job Title Attorney

Address 215 S. Monroe St, Suite 505 Phone 205-9020
Street

TLH FL 32301 E-mail greg.black@metzlaw.com
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Business Law Section, Florida Bar

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 Committee on Banking and Insurance

BILL:	CS/SB 1408
INTRODUCER:	Banking and Insurance Committee and Senator Richter
SUBJECT:	Captive Insurance
DATE:	April 10, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.			CM	
3.			AP	
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:

CS/SB 1408 strikes the reference to "satisfactory non-approved reinsurer" from the definition of a qualifying reinsurer parent company, and replaces it with a reference to "trusteed reinsurer," as being considered to be a qualifying reinsurer parent company. The CS removes the current allowance for a qualifying reinsurer parent company to hold a letter of eligibility as an acceptable alternative to holding a certificate of authority. The CS allows an industrial insured captive insurance company to insure risks of its stockholders or members, and affiliates thereof, or the stockholders or affiliates of the parent corporation of the captive insurer. The CS allows an industrial insured captive insurer with unencumbered capital and surplus of at least $20 million to be licensed to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate. The CS exempts captive insurers from the statutory trust deposit required under s. 624.411, F.S., as a condition of obtaining a certificate of authority to transact insurance. The CS requires a pure captive insurance company to submit to the OIR for approval its standards to ensure a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business that is to be insured by the pure captive insurance company. The CS deletes the current authorization for the Financial Services Commission to adopt rules establishing such standards.

This bill substantially amends the following sections of the Florida Statutes: 628.901, 628.905, 628.907, 628.909, 628.9142, 628.915, 628.917, and 628.919.

II. Present Situation:

A captive insurance company is an insurer that primarily or exclusively insures a business entity, or entities, that owns or is an affiliate of the captive insurer. The insured business entities pay premiums to the captive insurance company for specified insurance coverages. Under current law, captive insurance is regulated by the Office of Insurance Regulation (OIR) under part V of ch. 628, F.S., which defines a "captive insurance company" as a domestic insurer established under part V, and includes a pure captive insurance company, a special purpose captive insurance company, or an industrial captive insurance company, with each of these formations also separately defined. Each formation may vary in allowable corporate structure, capital and surplus, underwritten risks, and number of owners. Most captive insurance companies are formed as pure captives,[1] meaning that the captive is a wholly-owned subsidiary that insures the risks of its parent and affiliates.[2]

An "industrial insured captive insurance company"[3] is defined as a captive insurance company that provides insurance only to industrial insureds that are its stockholders or members, or affiliates of the stockholders or members, or to the stockholders of its parent corporation, or their affiliates. An industrial insured captive insurance company can also provide reinsurance, but only on risks written by direct insurer for the industrial insureds that are the stockholders or members, and affiliates thereof, of the industrial insured captive insurance company, or to the stockholders of the parent corporation, or their affiliates, of the industrial insured captive insurance company.

An "industrial insured"[4] is defined as an insured that:

- Has gross assets in excess of $50 million;
- Procures insurance through the use of a full-time employee who acts as an insurance manager or through the services of a person licensed as a property and casualty insurance agent in his or her state of domicile;
- Has at least 100 full-time employees; and
- Pays annual premiums of at least $200,000 for each line of insurance purchased from the industrial insured captive insurance company or at least $75,000 for any line of coverage in excess of at least $25 million in the annual aggregate.

A "captive reinsurance company"[5] is defined as a stock corporation reinsurer formed under part V of ch. 628, F.S., that is wholly owned by a qualifying reinsurance parent company. A "qualifying reinsurance parent company" is defined as a reinsurer that:

- Holds a certificate of authority or a letter of eligibility; or

[1] Theriault, Patrick. Captive Insurance Companies (2008). Page 9. www.captive.com.
[2] S. 628.901(12), F.S.
[3] S. 628.901(9), F.S.
[4] S. 628.901(8), F.S.
[5] S. 628.901(3), F.S.

- Is an accredited or a satisfactory non-approved reinsurer in Florida and possesses consolidated GAAP net worth of at least $500 million and a consolidated debt to total capital ratio of not greater than 0.50.

A captive insurance arrangement can provide a number of benefits, depending on the type of business arrangement, the domicile of the insured business and the captive insurer, and the coverages involved. Some benefits of captive insurance may include:

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

Potential disadvantages of a captive insurance arrangement may include:

- Administrative Costs. Forming a captive may require extra personnel and management as well as time and attention that can distract from the core business of the parent company or companies. Administering a possible acquisition or merger may also become more complicated when a captive is involved. Regulatory compliance is an additional component that may impose added administrative costs.
- Long-term Financial Risks. The formation of a captive insurer is a long-term investment with benefits that often are not realized immediately. Captives may also expose a company to increased risk and exposure to volatile capital and reinsurance markets. The financial commitment to a captive insurer is less flexible than the simple purchase of an annual policy through a commercial insurer.

In 2012, the Legislature passed and the Governor signed CS/CS/HB 1101 into law,[6] which made significant changes to Florida's captive insurance statute. These changes were intended to modernize the statute and make Florida more attractive to companies seeking to domicile captive insurance companies in the state, which could help generate new jobs and revenues. Among its numerous provisions, the law:

- Adopted new definitions for pure captive insurance companies, special purpose captive insurance companies, and industrial insured captive insurance companies;

[6] Sections 19 – 34, ch. 2012-151, L.O.F.

- Allowed the formation and incorporation of different varieties of captive insurance and reinsurance companies;
- Substantially reduced the capital and surplus requirements for industrial insured captives and pure captives;
- Established new procedures for licensure of captive insurers or reinsurers by the Office of Insurance Regulation (OIR);
- Fixed annual reporting requirements applicable to captive insurance companies;
- Provided net asset requirements for nonprofit captive insurance companies formed as pure captives and special purpose captives;
- Required the Financial Services Commission to set standards ensuring that a parent or affiliated company exercises risk management control of any unaffiliated business to be insured by a pure captive; and
- Restricted the allowable coverage a captive insurer or reinsurer may provide. Prior to CS/CS/HB 1101, an industrial insured captive insurer was permitted to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate. CS/CS/HB 1101 removed that provision. This provision negatively affected the ability of at least one currently existing captive insurer to write new policies for workers' compensation and excess employer liability coverage.

III. Effect of Proposed Changes:

Section 1 amends s. 628.901(13), F.S., relating to the definition of "qualifying reinsurer parent company." The current definition includes a reference to a "satisfactory non-approved reinsurer" as being considered to be a qualifying reinsurer parent company. The CS strikes the reference to "satisfactory non-approved reinsurer" from the definition, and replaces it with a reference to "trusteed reinsurer,"[7] as being considered to be a qualifying reinsurer parent company. The CS also removes the current allowance for a qualifying reinsurer parent company to hold a letter of eligibility as an acceptable alternative to holding a certificate of authority.

Section 2 amends s. 628.905, F.S., to allow an industrial insured captive insurance company to insure risks of its stockholders or members, and affiliates thereof, or the stockholders or affiliates of the parent corporation of the captive insurer. The CS also allows an industrial insured captive insurer with unencumbered capital and surplus of at least $20 million to be licensed to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate. The captive insurer must maintain unencumbered capital and surplus of at least $20 million to continue writing excess workers' compensation insurance.

Section 4 amends s. 628.909, F.S., to exempt captive insurers from the statutory trust deposit required under s. 624.411, F.S., as a condition of obtaining a certificate of authority to transact insurance.

Sections 3, 5, 6, and 7 make technical amendments to ss. 628.907, 628.9142, 628.915, and s. 628.917, F.S., related to captive insurers.

Section 8 amends s. 628.919, F.S., to require a pure captive insurance company to submit to the

[7] S. 624.610(3)(c), F.S.

OIR for approval its standards to ensure a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business that is to be insured by the pure captive insurance company. The CS deletes the current authorization for the Financial Services Commission to adopt rules establishing such standards.

Section 9 provides an effective date of July 1, 2013.

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.)

CS by Banking and Insurance on April 9, 2013:

The CS removes the original bill's redefinition of "captive insurance company," and the bill's new definitions for "incorporated protected cell," "participant," "protected cell," "incorporated protected cell, and" "protected cell subsidiary company."
The CS removes the original bill's provision to allow that a protected cell subsidiary company can insure or reinsure risks.

The CS removes the original bill's provision to provide that a protected cell subsidiary company must possess and maintain unimpaired paid-in capital of at least $200,000 and unimpaired surplus of at least $300,000.

The CS removes the original bill's provision to make conforming changes to add protected cell subsidiary companies to the applicability of specific provisions of the Insurance Code.

The CS removes the original bill's provision to provide that a protected cell subsidiary company must be incorporated as a stock insurer with its capital divided into shares that are held by its industrial insured captive insurance company parent.

The CS removes the original bill's provision to provide that a ceding captive insurance company can reinsure risks with an assuming insurer for the limited purpose of assuming risk from a protected cell subsidiary company with respect to one or more protected cells.

The CS removes the original bill's provision to remove current language that provides that an industrial insured captive insurer is prohibited from joining or from receiving any benefit from a joint underwriting association or guaranty fund.

The CS removes the original bill's creation of new s. 628.921, F.S., governing the establishment of protected cells, the formation of and requirements for protected cell subsidiary companies, defining the term "incorporated protected cell," and establishing provisions for the formation of and requirements for incorporated protected cells.

The CS amends the definition of "qualifying reinsurer parent company," to delete a reference to a "satisfactory non-approved reinsurer," and replace it with a reference to "trusteed reinsurer."

The CS removes the current allowance for a qualifying reinsurer parent company to hold a letter of eligibility as an acceptable alternative to holding a certificate of authority.

The CS requires that an industrial insured captive insurer must have unencumbered capital and surplus of at least $20 million to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate.

The CS exempts captive insurers from the statutory trust deposit required as a condition of obtaining a certificate of authority to transact insurance.

The CS requires a pure captive insurance company to submit to the OIR for approval its standards to ensure a parent or affiliated company is able to exercise control of the risk

management function of any controlled unaffiliated business that is to be insured by the pure captive insurance company. The CS deletes the current authorization for the Financial Services Commission to adopt rules establishing these standards.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/09/2013	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsections (8), (9), and (13) of section 628.901, Florida Statutes, are amended to read:

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

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

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

(b) Procures insurance through the use of a full-time employee of the insured who acts as an insurance manager or buyer or through the services of a person licensed as a property

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and casualty insurance agent, broker, or consultant in such person's state of domicile;

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

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

(9) "Industrial insured captive insurance company" means a ~~captive insurance~~ company that provides insurance only to the industrial insureds that are its stockholders or members, and affiliates thereof, or to the stockholders, and affiliates thereof, of its parent corporation. An industrial insured captive insurance company may ~~can~~ also provide reinsurance to insurers only on risks written by such insurers for the industrial insureds that are the stockholders or members, and affiliates thereof, of the industrial insured captive insurance company ~~insurer~~, or the stockholders, and affiliates thereof, of the parent corporation of the industrial insured captive insurance company ~~insurer~~.

(13) "Qualifying reinsurer parent company" means a reinsurer that ~~which~~ currently holds a certificate of authority~~,~~ ~~letter of eligibility~~ or is an accredited or trusteed ~~a satisfactory non-approved~~ reinsurer under s. 624.610(3)(c) in this state possessing a consolidated GAAP net worth of at least $500 million and a consolidated debt to total capital ratio of not greater than 0.50.

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Section 2. Subsections (1) and (2), paragraph (b) of subsection (4), and subsection (5) of section 628.905, Florida Statutes, are amended to read:

628.905 Licensing; authority.—

(1) A captive insurance company ~~insurer~~, if permitted by its charter or articles of incorporation, may apply to the office for a license to do any ~~and all~~ insurance authorized under the insurance code, other than workers' compensation and employer's liability, life, health, personal motor vehicle, and personal residential property insurance, except that:

(a) A pure captive insurance company may not insure any risks other than those of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.

(b) An industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies, or its stockholders or members and affiliates thereof of the industrial insured captive, or the stockholders or affiliates of the parent corporation of the industrial insured captive insurance company.

(c) A special purpose captive insurance company may insure only the risks of its parent.

(d) A captive insurance company may not accept or cede reinsurance except as provided under ~~in~~ this part.

(e) An industrial insured captive insurance company that has unencumbered capital and surplus of at least $20 million may be licensed to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate. An industrial insured captive insurance company must

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maintain unencumbered capital and surplus of at least $20 million in order to continue to write excess workers' compensation insurance in this state.

(2) To conduct insurance business in this state, a captive insurance company ~~insurer~~ must:

(a) Obtain from the office a license authorizing it to conduct insurance business in this state;

(b) Hold at least one board of directors' meeting each year in this state;

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

(d) Appoint a resident registered agent to accept service of process and to otherwise act on its behalf in this state. In the case of a captive insurance company formed as a corporation or a nonprofit corporation, if the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Chief Financial Officer is ~~of this state must be~~ an agent of the captive insurance company upon whom any process, notice, or demand may be served.

(4) A captive insurance company or captive reinsurance company must pay to the office a nonrefundable fee of $1,500 for processing its application for license.

(b) The office may charge a fee of $5 for any document requiring certification of authenticity or the signature of the office ~~commissioner or his or her designee~~.

(5) If the office ~~commissioner~~ is satisfied that the documents and statements filed by the captive insurance company comply with this chapter, the office ~~commissioner~~ may grant a license authorizing the company to conduct insurance business in

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this state until the next succeeding March 1, at which time the license may be renewed.

Section 3. Subsection (1) of section 628.907, Florida Statutes, is amended to read:

628.907 Minimum capital and net assets requirements; restriction on payment of dividends.—

(1) A captive insurance company ~~insurer~~ may not be issued a license unless it possesses and thereafter maintains unimpaired paid-in capital of:

(a) In the case of a pure captive insurance company, at least $100,000.

(b) In the case of an industrial insured captive insurance company incorporated as a stock insurer, at least $200,000.

(c) In the case of a special purpose captive insurance company, an amount determined by the office after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.

Section 4. Section 628.909, Florida Statutes, is amended to read:

628.909 Applicability of other laws.—

(1) The Florida Insurance Code does not apply to captive insurance companies ~~insurers~~ or industrial insured captive insurance companies ~~insurers~~ except as provided under ~~in~~ this part and subsections (2) and (3).

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

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.411, 624.425, and 624.426.

(b) Chapter 625, part II.

(c) Chapter 626, part IX.

(d) Sections 627.730-627.7405, if ~~when~~ no-fault coverage is provided.

(e) Chapter 628.

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

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.411, 624.425, 624.426, and 624.609(1).

(b) Chapter 625, part II, if the industrial insured captive insurance company ~~insurer~~ is incorporated in this state.

(c) Chapter 626, part IX.

(d) Sections 627.730-627.7405 if ~~when~~ no-fault coverage is provided.

(e) Chapter 628, except for ss. 628.341, 628.351, and 628.6018.

Section 5. Subsection (2) of section 628.9142, Florida Statutes, is amended to read:

628.9142 Reinsurance; effect on reserves.—

(2) A captive insurance company may take credit for reserves on risks or portions of risks ceded to authorized insurers or reinsurers and unauthorized insurers or reinsurers complying with s. 624.610. A captive insurance company ~~insurer~~ may not take credit for reserves on risks or portions of risks ceded to an unauthorized insurer or reinsurer if the insurer or

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reinsurer is not in compliance with s. 624.610.

Section 6. Section 628.915, Florida Statutes, is amended to read:

628.915 Exemption from compulsory association.—

(1) A ~~No~~ captive insurance company may not ~~insurer shall be permitted to~~ join or contribute financially to a ~~any~~ joint underwriting association or guaranty fund in this state; nor may a ~~shall any~~ captive insurance company ~~insurer~~, its insured, or its parent or any affiliated company receive any benefit from any ~~such~~ joint underwriting association or guaranty fund for claims arising out of the operations of such captive insurance company ~~insurer~~.

(2) An ~~No~~ industrial insured captive insurance company may not ~~insurer shall be permitted to~~ join or contribute financially to a ~~any~~ joint underwriting association or guaranty fund in this state; nor may an ~~shall any~~ industrial insured captive insurance company ~~insurer~~, its industrial insured, or its parent or any affiliated company receive any benefit from any ~~such~~ joint underwriting association or guaranty fund for claims arising out of the operations of such industrial insured captive insurance company ~~insurer~~.

Section 7. Section 628.917, Florida Statutes, is amended to read:

628.917 Insolvency and liquidation.—If ~~In the event that~~ a captive insurance company ~~insurer~~ is insolvent as defined in chapter 631, the office shall liquidate the captive insurance company ~~insurer~~ pursuant to ~~the provisions of~~ part I of chapter 631,~~;~~ except that the office may ~~shall~~ make no attempt to rehabilitate such company ~~insurer~~.

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Section 8. Section 628.919, Florida Statutes, is amended to read:

628.919 Standards to ensure risk management control by parent company.—A pure captive insurance company must submit ~~The Financial Services Commission shall adopt rules establishing~~ standards to the office which ensure that a parent or affiliated company is able to exercise control of the risk management function of a ~~any~~ controlled unaffiliated business to be insured by the pure captive insurance company.

Section 9. This act shall take effect July 1, 2013.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to captive insurance; replacing the term "captive insurer" with "captive insurance company" in part V of ch. 628, F.S.; amending s. 628.901, F.S.; revising definitions; amending s. 628.905, F.S.; expanding the risks that an industrial insured capital insurance company may insure; providing that an industrial insured captive insurance company may provide certain insurance if the company has and maintains unencumbered capital and surplus of a certain amount; amending s. 628.907, F.S.; conforming terms; amending s. 628.909, F.S.; conforming terms and requiring captive insurance companies to deposit and maintain securities for the

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protection of policyholders; amending ss. 628.9142, 628.915, 628.917, and 628.919, F.S.; conforming terms; providing an effective date.

By Senator Richter

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A bill to be entitled

An act relating to captive insurance; amending s. 628.901, F.S.; revising definitions and providing definitions; amending s. 628.905, F.S.; revising terminology; providing that protected cell subsidiary companies are limited to only insuring or reinsuring certain risks through protected cells; authorizing industrial insured captive insurance companies or protected cell subsidiary companies to insure or reinsure certain risks with respect to excess workers compensation and employer's liability insurance and excess life and health insurance; limiting an industrial insured captive insurance company from providing coverage with respect to such excess workers compensation and employer's liability insurance under certain circumstances; amending s. 628.907, F.S.; revising terminology; requiring a protected cell subsidiary company to have a minimum amount of unimpaired paid-in capital in order to be issued a license; amending s. 628.908, F.S.; requiring a protected cell subsidiary company to have a minimum amount of unimpaired surplus in order to be issued a license; amending s. 628.909, F.S.; providing that specified provisions of the insurance code apply, or do not apply, to captive insurance companies, industrial insured captive insurance companies, or protected cell subsidiary companies; amending s. 628.910, F.S.; requiring a protected cell subsidiary company to be incorporated in a specified manner;

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amending s. 628.9142, F.S.; conforming provisions; authorizing a ceding captive insurance company to reinsure certain risks of a protected cell subsidiary company with respect to protected cells under specified circumstances; authorizing credit for reserves on certain risks assumed through reinsurance; amending s. 628.915, F.S.; conforming provisions; deleting a provision prohibiting industrial insured captive insurers from joining or contributing to any joint underwriting association or guaranty fund; deleting a provision prohibiting such insurers and specified others from receiving certain benefits from such associations or guaranty funds; amending s. 628.917, F.S.; conforming provisions; creating s. 628.921, F.S.; authorizing industrial insured captive insurance companies to form protected cell subsidiary companies; authorizing protected cell subsidiary companies to establish protected cells; providing conditions and requirements with respect to the formation of such subsidiaries, the establishment of such cells, and the conduct of operations of such entities; providing an effective date.

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

Section 1. Section 628.901, Florida Statutes, is amended to read:

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

(1) "Affiliated company" means a company in the same

corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(2) "Captive insurance company" means a domestic insurer established under this part or an industrial insured captive insurance company licensed under this part. A captive insurance company includes a pure captive insurance company, special purpose captive insurance company, ~~or~~ industrial insured captive insurance company, or protected cell subsidiary company formed and licensed under this part.

(3) "Captive reinsurance company" means a reinsurance company that is formed and licensed under this part and is wholly owned by a qualifying reinsurance parent company. A captive reinsurance company is a stock corporation and may not directly insure risks. A captive reinsurance company may reinsure only risks.

(4) "Consolidated debt to total capital ratio" means the ratio of the sum of all debts and hybrid capital instruments as described in paragraph (a) to total capital as described in paragraph (b).

(a) Debts and hybrid capital instruments include, but are not limited to, all borrowings from banks, all senior debt, all subordinated debts, all trust preferred shares, and all other hybrid capital instruments that are not included in the determination of consolidated GAAP net worth issued and outstanding.

(b) Total capital consists of all debts and hybrid capital instruments as described in paragraph (a) plus owners' equity determined in accordance with GAAP for reporting to the United

States Securities and Exchange Commission.

(5) "Consolidated GAAP net worth" means the consolidated owners' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(6) "Controlled unaffiliated business" means a company:

(a) That is not in the corporate system of a parent and affiliated companies;

(b) That has an existing contractual relationship with a parent or affiliated company; and

(c) Whose risks are managed by a captive insurance company in accordance with s. 628.919.

(7) "GAAP" means generally accepted accounting principles.

(8) "Incorporated protected cell" means a company formed in accordance with s. 628.921(2).

(9) ~~(8)~~ "Industrial insured" means an insured that:

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

(b) Procures insurance through the use of a full-time employee of the insured who acts as an insurance manager or buyer or through the services of a person licensed as a property and casualty insurance agent, broker, or consultant in such person's state of domicile;

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

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

be deemed to be the purchase of a single line of insurance.

(10)~~(9)~~ "Industrial insured captive insurance company" means a ~~captive insurance~~ company that provides insurance only:

(a) To the industrial insureds that are its stockholders or members, and affiliates thereof;~~, or~~

(b) To the stockholders, and affiliates thereof, of its parent corporation;

(c) A controlled unaffiliated business; or

(d) Any combination thereof.

An industrial insured captive insurance company can also provide reinsurance to insurers only on risks written by such insurers for the industrial insureds that are the stockholders or members, and affiliates thereof, of the industrial insured captive insurer, or the stockholders, and affiliates thereof, of the parent corporation of the industrial insured captive insurer.

(11)~~(10)~~ "Office" means the Office of Insurance Regulation.

(12)~~(11)~~ "Parent" means any corporation, limited liability company, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the outstanding voting interests of a captive insurance company.

(13) "Participant" means an industrial insured or its affiliated company or companies, or its controlled affiliate business, which are insured by a protected cell subsidiary company, where the losses of it are limited to the assets of one or more protected cells.

(14) "Participant agreement" means a contract by which one

or more participants and a protected cell subsidiary company agree on the terms governing the operation of a protected cell and the insuring arrangement with the protected cell subsidiary company.

(15) "Protected cell" means a separate account established and maintained by a protected cell subsidiary company for one or more participants in accordance with the participant agreement and includes an "incorporated protected cell" as defined in subsection (8).

(16) "Protected cell subsidiary company" means a company that has as its sole stockholder an industrial insured captive insurance company and only insures or reinsures risks through protected cells in accordance with s. 628.921.

(17)~~(12)~~ "Pure captive insurance company" means a company that insures risks of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.

(18)~~(13)~~ "Qualifying reinsurer parent company" means a reinsurer which currently holds a certificate of authority, letter of eligibility or is an accredited or a satisfactory non-approved reinsurer in this state possessing a consolidated GAAP net worth of at least $500 million and a consolidated debt to total capital ratio of not greater than 0.50.

(19)~~(14)~~ "Special purpose captive insurance company" means a ~~captive insurance~~ company that is formed or licensed under this chapter that does not meet the definition of any other type of captive insurance company defined in this section.

(20)~~(15)~~ "Treasury rates" means the United States Treasury STRIPS asked yield as published in the Wall Street Journal as of a balance sheet date.

Section 2. Subsections (1) and (2) of section 628.905, Florida Statutes, are amended to read:

628.905 Licensing; authority.—

(1) A captive insurance company ~~insurer~~, if permitted by its charter or articles of incorporation, may apply to the office for a license to do any and all insurance authorized under the insurance code, other than workers' compensation, subject to paragraph (f), and employer's liability, life, health, personal motor vehicle, and personal residential property insurance, except that:

(a) A pure captive insurance company may not insure any risks other than those of its parent, affiliated companies, controlled unaffiliated businesses, or a combination thereof.

(b) An industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group or its stockholders, ~~and~~ their affiliated companies, stockholders or affiliates of its parent corporation, controlled unaffiliated businesses, or any combination thereof.

(c) A protected cell subsidiary company may insure or reinsure risks only through protected cells in accordance with s. 628.921 and may not insure or reinsure any risks other than those of the industrial insureds and their affiliated companies, who are the stockholders or members of the industrial insured captive insurance company that is the sole stockholder of such protected cell subsidiary company, controlled unaffiliated businesses, or a combination thereof.

(d) ~~(c)~~ A special purpose captive insurance company may insure only the risks of its parent.

(e) ~~(d)~~ A captive insurance company may not accept or cede reinsurance except as provided in this part.

(f) 1. This section is not intended to preclude an industrial insured captive insurance company or a protected cell subsidiary company, as determined by the industrial insured and its affiliated companies, from insuring or reinsuring the following risks if such risks relate to benefits provided by such industrial insured or its affiliated companies to employees or retired employees:

a. The excess workers compensation and employer's liability risks of an industrial insured and its affiliated companies; or

b. The excess life and health risks of an industrial insured and its affiliated companies.

2. An industrial insured captive insurance company may not provide workers' compensation and employer's liability insurance as authorized under sub-subparagraph a., except in excess of at least $25 million in the annual aggregate.

(2) To conduct insurance business in this state, a captive insurance company ~~insurer~~ must:

(a) Obtain from the office a license authorizing it to conduct insurance business in this state;

(b) Hold at least one board of directors' meeting each year in this state;

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

(d) Appoint a resident registered agent to accept service of process and to otherwise act on its behalf in this state. In the case of a captive insurance company formed as a corporation or a nonprofit corporation, if the registered agent cannot with

reasonable diligence be found at the registered office of the captive insurance company, the Chief Financial Officer of this state must be an agent of the captive insurance company upon whom any process, notice, or demand may be served.

Section 3. Subsection (1) of section 628.907, Florida Statutes, is amended to read:

628.907 Minimum capital and net assets requirements; restriction on payment of dividends.—

(1) A captive insurance company ~~insurer~~ may not be issued a license unless it possesses and thereafter maintains unimpaired paid-in capital of:

(a) In the case of a pure captive insurance company, at least $100,000.

(b) In the case of an industrial insured captive insurance company incorporated as a stock insurer, at least $200,000.

(c) In the case of a protected cell subsidiary company, at least $200,000.

(d)~~(c)~~ In the case of a special purpose captive insurance company, an amount determined by the office after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.

Section 4. Subsection (1) of section 628.908, Florida Statutes, is amended to read:

628.908 Surplus requirements; restriction on payment of dividends.—

(1) The office may not issue a license to a captive insurance company unless the company possesses and maintains unimpaired surplus of:

(a) In the case of a pure captive insurance company, at least $150,000.

(b) In the case of an industrial insured captive insurance company incorporated as a stock insurer, at least $300,000.

(c) In the case of an industrial insured captive insurance company incorporated as a mutual insurer, at least $500,000.

(d) In the case of a protected cell subsidiary company, at least $300,000.

(e)~~(d)~~ In the case of a special purpose captive insurance company, an amount determined by the office after giving due consideration to the company's business plan, feasibility study, and pro forma financial statements and projections, including the nature of the risks to be insured.

Section 5. Section 628.909, Florida Statutes, is amended to read:

628.909 Applicability of other laws.—

(1) The Florida Insurance Code does not apply to captive insurance companies ~~insurers~~ or industrial insured captive insurers except as provided in this part and subsections (2) and (3).

(2) The following provisions of the Florida Insurance Code apply to captive insurance companies ~~insurers~~ who are not industrial insured captive insurance companies or protected cell subsidiary companies ~~insurers~~ to the extent that such provisions are not inconsistent with this part:

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

(b) Chapter 625, part II.

(c) Chapter 626, part IX.

(d) Sections 627.730-627.7405, when no-fault coverage is provided.

(e) Chapter 628.

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

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

(b) Chapter 625, part II, if the industrial insured captive insurance company ~~insurer~~ is incorporated in this state.

(c) Chapter 626, part IX.

(d) Sections 627.730-627.7405 when no-fault coverage is provided.

(e) Chapter 628, except for ss. 628.341, 628.351, and 628.6018.

Section 6. Subsections (3) through (9) of section 628.910, Florida Statutes, are renumbered as subsections (4) through (10), respectively, and subsection (3) is added to that section, to read:

628.910 Incorporation options and requirements.—

(3) A protected cell subsidiary company must be incorporated as a stock insurer with its capital divided into shares that are held by its industrial insured captive insurance company parent.

Section 7. Section 628.9142, Florida Statutes, is amended to read:

628.9142 Reinsurance; effect on reserves.—

(1) A captive insurance company may provide reinsurance, as

authorized in this part, on risks ceded by any other insurer.

(2) A captive insurance company may take credit for reserves on risks or portions of risks ceded to authorized insurers or reinsurers and unauthorized insurers or reinsurers complying with s. 624.610. A captive insurance company ~~insurer~~ may not take credit for reserves on risks or portions of risks ceded to an unauthorized insurer or reinsurer if the insurer or reinsurer is not in compliance with s. 624.610.

(3) In addition to the authority granted under subsection (2), a ceding captive insurance company may reinsure all or any part of any particular risk or class of risks with an assuming insurer approved by the office for the limited purpose of assuming risk from a protected cell subsidiary company with respect to one or more protected cells. Subject to the other requirements of this code, credit may be taken for reserves on risks assumed through reinsurance approved under this subsection.

Section 8. Section 628.915, Florida Statutes, is amended to read:

628.915 Exemption from compulsory association.—

~~(1)~~ No captive insurance company ~~insurer~~ shall be permitted to join or contribute financially to any joint underwriting association or guaranty fund in this state; nor shall any captive insurance company ~~insurer~~, its insured, or its parent or any affiliated company receive any benefit from any such joint underwriting association or guaranty fund for claims arising out of the operations of such captive insurance company ~~insurer~~.

~~(2) No industrial insured captive insurer shall be permitted to join or contribute financially to any joint~~

~~underwriting association or guaranty fund in this state; nor shall any industrial insured captive insurer, its industrial insured, or its parent or any affiliated company receive any benefit from any such joint underwriting association or guaranty fund for claims arising out of the operations of such industrial insured captive insurer.~~

Section 9. Section 628.917, Florida Statutes, is amended to read:

628.917 Insolvency and liquidation.—In the event that a captive insurance company ~~insurer~~ is insolvent as defined in chapter 631, the office shall liquidate the captive insurance company ~~insurer~~ pursuant to the provisions of part I of chapter 631; except that the office shall make no attempt to rehabilitate such insurer.

Section 10. Section 628.921, Florida Statutes, is created to read:

628.921 Formation of protected cell subsidiary company; establishing protected cells.—An industrial insured captive insurance company may form a protected cell subsidiary company under this part. A protected cell subsidiary company that is formed or licensed under this part may establish and maintain one or more protected cells to insure or reinsure risks of one or more participants or affiliated companies of such participants, subject to the following conditions:

(1) A protected cell of a protected cell subsidiary company may not be established or terminated without the commissioner's prior written approval, and no participant may be added to or withdrawn from any existing protected cell without the commissioner's prior written approval.

(2) The business plan of a protected cell subsidiary company must include a description of its operations with respect to each protected cell. Once approved for one kind of insurance authorized under the insurance code, the protected cell subsidiary company is authorized to write such kind of insurance with respect to any of its protected cells, provided the establishment of such protected cells has previously been approved by the commissioner.

(3) Each protected cell must be accounted for separately on the books and records of the protected cell subsidiary company to reflect the financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions to participants and their affiliated companies, and other factors that may be provided in the participant agreement or required by the commissioner.

(4) The assets of a protected cell may not be chargeable with liabilities arising out of any other insurance business the protected cell subsidiary company may conduct, except pursuant to a written agreement approved by the commissioner between the protected cell subsidiary company and the participants of each protected cell being charged with such liabilities.

(5) No insurance policy may be issued or reinsurance assumed with respect to a protected cell unless such insurance policy or reinsurance agreement contains terms providing that:

(a) The amount of all claims by insureds or reinsureds of the protected cell may not exceed the aggregate of the funds designated by the protected cell subsidiary company as being funds held with respect to such protected cell;

(b) In the event that the funds held by the protected cell

subsidiary company are insufficient to pay all such claims, the claims must be reduced, as provided in the insurance policy or reinsurance agreement, or if no such provision is made for reduction in claim amounts, in the sole discretion of the board of directors of the protected cell subsidiary company; and

(c) A claim may not be made under such insurance policy or reinsurance agreement on any funds held by the protected cell subsidiary company other than those funds held with respect to the protected cell under which the insurance policy was issued or reinsurance assumed.

Any insurance policy issued or reinsurance assumed which does not contain these provisions must nevertheless be deemed to have such provisions and the reduction in claim amounts referred to in paragraph (b) must be made on an equitable basis in the sole discretion of the board of directors of the protected cell subsidiary company.

(6) Sale, exchange, or other transfer of assets may not be made by the protected cell subsidiary company between or among any of its protected cells without the consent of the protected cells.

(7) Sale, exchange, transfer of assets, dividend, or distribution may not be made from a protected cell to a shareholder or a participant of the protected cell subsidiary company without the commissioner's approval, nor may the approval be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to a protected cell.

(8) A protected cell subsidiary company must notify the

commissioner in writing within 10 business days after a protected cell becomes insolvent or otherwise unable to meet its claim or expense obligations.

(9) With respect to incorporated protected cells:

(a) For purposes of this subsection, the term "incorporated protected cell" means a protected cell that is formed as a corporation or a limited liability company separate from the protected cell subsidiary company of which it is a part.

(b) A protected cell of a protected cell subsidiary company may be formed as an incorporated protected cell with limited liability separate from the protected cell subsidiary company, but the sole shareholder of an incorporated protected cell must be the shareholder that is the parent of the protected cell subsidiary company that forms the incorporated protected cell.

(c) The articles of incorporation or articles of organization of an incorporated protected cell must refer to the protected cell subsidiary company for which it is a protected cell and must state that the protected cell is incorporated or organized for the limited purposes authorized by the protected cell subsidiary company's license. A copy of the prior written approval of the commissioner to add the incorporated protected cell must be attached to and filed with the articles of incorporation or articles of organization.

(d) This subsection is intended to provide protected cell subsidiary companies with the option to establish one or more protected cells as a separate corporation or limited liability company. This subsection may not be construed to limit any rights or protections applicable to protected cells not established as corporations or limited liability companies.

(10) The following requirements are applicable to shareholders of protected cell subsidiary companies:

(a) The shareholder of a protected cell subsidiary company must be an industrial insured captive insurance company licensed as such under this chapter.

(b) A risk retention group may not be either a shareholder or a participant of a protected cell subsidiary company.

(11) The following apply to participants in protected cell subsidiary companies:

(a) Any industrial insured who is a stockholder or member, and its affiliated companies, of the industrial insured captive insurance company that is the parent of the protected cell subsidiary company may be a participant in such protected cell subsidiary company formed or licensed under this part.

(b) The industrial insured captive insurance company that is the parent of the protected cell subsidiary company may itself be a participant in the protected cell subsidiary company.

Section 11. This act shall take effect July 1, 2013.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 360
INTRODUCER:	Health Policy Committee and Senator Garcia
SUBJECT:	Surgical Assistants and Surgical Technologists
DATE:	April 6, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davlantes	Stovall	HP	**Fav/CS**
2.	Matiyow	Burgess	BI	**Favorable**
3.			AHS	
4.			AP	
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:

CS/SB 360 amends s. 395.0191, F.S., to add a new subsection concerning surgical technologists and surgical assistants. The CS provides various definitions. The CS prohibits a health care facility from employing or contracting with any person to perform the duties of a surgical assistant or surgical technologist unless that person is a certified surgical assistant or surgical technologist and also provides exceptions to these prohibitions.

This CS substantially amends the following section of the Florida Statutes: 395.0191.

II. Present Situation:

Role of Surgical Technologists

Surgical technologists, also called scrubs or operating room technicians,[1] work under the supervision of surgeons to ensure that the operating room environment is safe, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize

[1] United States Department of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2012-13 Edition: Surgical Technologists*, available at: http://www.bls.gov/oco/ocos106.htm (last visited on April 6, 2013).

patient safety. Surgical technologists are trained in aseptic technique and combine the knowledge of human anatomy, surgical procedures, and implementation tools and technologies to facilitate a physician's performance of invasive therapeutic and diagnostic procedures.[2] Currently, no statutes or rules are in place to regulate the practice of surgical technology in Florida.

The Association of Surgical Technology (AST) is the oldest and most recognized professional organization for surgical technologists and surgical assistants. The AST was established in 1969 by members of the American College of Surgeons, the American Hospital Association, and the Association of Perioperative Registered Nurses to ensure that surgical technologists and surgical assistants have the knowledge and skills to administer patient care of the highest quality. Some of the AST's duties include creating and administering national certification procedures for surgical technologists, providing continuing education for such certification, working with national accrediting committees to establish standards for training programs, and advocating the interests of surgical technologists to government entities.[3]

The AST has published national guidelines for the scope of practice of surgical technologists.[4] It designates three different categories of technologist, each with different functions. A scrub technologist maintains sterility and handles necessary instruments, supplies, and equipment during a surgical procedure. A circulating technologist assists the circulating nurse in obtaining additional instruments, supplies, and equipment during the procedure. A second assisting technologist maintains sterility and assists the surgeon and the surgeon's first assistant during the procedure. More detailed duties are as follows:

Scrub Technologist

- Check supplies and equipment needed for the surgical procedure.
- Scrub, gown, and glove.
- Set up the sterile table with instruments, supplies, equipment, and medications needed for the procedure.
- Perform appropriate counts with the circulator prior to the operation and before the incision is closed.
- Gown and glove the surgeon and assistants.
- Help in draping the sterile field.
- Pass instruments to the surgeon during the procedure.
- Prepare sterile dressings.
- Clean and prepare instruments for terminal sterilization.
- Assist other members of the surgical team with terminal cleaning of the operating room.
- Assist in preparing the operating room for the next patient.

Circulating Technologist

- Obtain appropriate sterile and unsterile items needed for the procedure.
- Open sterile supplies.

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[2] AST, *Job Description: Surgical Technologist*, available at: http://www.ast.org/professionals/documents/2009_Surgical_Technologist_Job_Description_10.6_Final.pdf (last visited on April 6, 2013).
[3] AST, *About Us*, available at : http://www.ast.org/aboutus/about_ast.aspx (last visited on April 6, 2013).
[4] *Supra* fn. 2.

- Check the patient's chart, identify the patient, verify the surgery to be performed with consent forms, and bring the patient to the assigned operating room.
- Transfer the patient to the operating table.
- Assess the patient's comfort and safety and provide verbal and tactile reassurance.
- Assist anesthesia personnel.
- Position the patient, using appropriate equipment.
- Apply electrosurgical grounding pads, tourniquets, monitors, etc., before the procedure begins.
- Prepare the patient's skin prior to draping by the surgical team.
- Perform appropriate counts with the scrub nurse or technologist prior to the operation and before the incision is closed.
- Anticipate additional supplies needed during the procedure.
- Keep accurate records throughout the procedure.
- Properly care for specimens.
- Secure dressings after incision closure.
- Help transport the patient to the recovery room.
- Assist in cleaning the operating room and in preparing for the next patient.

Second Assisting Technologist

- Hold retractors or instruments as directed by the surgeon.
- Sponge or suction the operative site.
- Apply electrocautery to clamps on bleeding blood vessels.
- Cut suture material as directed by the surgeon.
- Connect drains to suction apparatus.
- Apply dressings to the closed wound.

Education and Certification

Surgical technologists must have a high school degree or equivalent and complete a training program accredited by the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools. The training program includes classroom education in anatomy, microbiology, pharmacology, ethics, medical terminology, and other topics as well as supervised clinical experience. Surgical technologist training lasts from 9-24 months and culminates in a certificate, diploma, or associate's degree.

Professional certification is not required for employment as a surgical technologist, although most employers prefer to hire only certified individuals.[5] Professional certification is available through the AST as a Certified Surgical Technologist (CST).[6] Requirements for CST designation include graduation from an accredited surgical technology program (with special exceptions for military-trained technologists), payment of fees, and passage of an examination offered by the National Board of Surgical Technology and Surgical Assisting (NBSTSA).[7] The CST certification is valid for 4 years; to renew, an individual must either retake and pass the NBSTSA

[5] *Supra* fn. 1.
[6] *Id.*
[7] NBSTSA, *CST Examinations*, available at: http://nbstsa.org/examinations-cst.html (last visited on April 6, 2013).

examination required for initial certification or complete 60 hours of continuing education. A renewal fee is also required.[8]

National certification may also be obtained from the National Center for Competency Testing (NCCT),[9] which awards the "Tech in Surgery-Certified (NCCT)" designation. Applicants must graduate from an NCCT-approved surgical technology program, complete required practical experience, and pass the organization's certification exam. Applicants who did not graduate from an approved surgical technology program may also qualify for certification if they have accrued some amount of practical experience, which varies depending on the situation. Passage of the examination and payment of fees is still required, however.[10] The NCCT certification must be renewed annually by completing 14 hours of continuing education and paying a recertification fee.[11]

Currently, there are approximately 4,800 surgical technologists employed in Florida. Of these, more than 3,400 are CSTs, and a few dozen hold the Tech in Surgery-Certified (NCCT) designation.[12]

Role of Surgical First Assistants

Surgical assistants provide aid in exposure, hemostasis, closure, and other intraoperative technical functions under the direct supervision of surgeons to help carry out safe operations with optimal results for patients. In addition to intraoperative duties, surgical assistants also perform preoperative and postoperative duties to better facilitate proper patient care.[13] Surgical first assistants provide primary assistance to the primary surgeon, must be listed on the operative record as first assistants, and cannot be involved in any other role during the procedure.[14] The primary professional organizations for surgical assistants are the Association of Surgical Technology (AST) and the National Surgical Assistant Association (NSAA). The AST was established in 1969 by members of the American College of Surgeons, the American Hospital Association, and the Association of Perioperative Registered Nurses to ensure that surgical technologists and surgical assistants have the knowledge and skills to administer patient care of the highest quality.[15] The NSAA was formed by surgical assistants in 1983 and was the nation's first organization to provide standards for competency, professionalism, and scope of practice in the field.[16]

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[8] NBSTSA, *Renewal Options*, available at: http://nbstsa.org/renewal/index.html (last visited on April 6, 2013).
[9] The NCCT is an independent entity which provides competency examinations and certifications for a variety of allied health professions, including medical assistants, phlebotomy technicians, patient care technicians, surgical technologists, and medical office assistants. It is not a professional organization. (Source: NCCT, *National Center for Competency Testing (NCCT)*, http://www.ncctinc.com/General/, last visited on April 6, 2013).
[10] NCCT, *Certification Information*, available at: http://www.ncctinc.com/Certifications/ (last visited on April 6, 2013).
[11] NCCT, *Recertification/CE*, available at http://www.ncctinc.com/CE/ (last visited on April 6, 2013).
[12] Email correspondence with the Florida State Assembly of the Association of Surgical Technologists. A copy of this correspondence is on file with the Senate Health Policy Committee.
[13] Association of Surgical Technologists, *Job Description: Surgical Assistant*, available at: http://www.ast.org/professionals/documents/2011_%20Surgical%20Assistant_Job_Description_4.5.pdf (last visited on April 6, 2013).
[14] American Board of Surgical Assistants, *Definitions*, available at: http://www.absa.net/definitions.php (last visited on April 6, 2013).
[15] AST, *About Us*, available at : http://www.ast.org/aboutus/about_ast.aspx (last visited on April 6, 2013).
[16] NSAA, *Welcome*, available at: http://www.nsaa.net/index.php (last visited on April 6, 2013).

Duties within the scope of practice of a surgical assistant include positioning the patient; providing visualization of the operative site, including appropriate placement of retractors, suctioning and sponging, and manipulation of suture materials; assisting with hemostasis; participating in volume replacement or autotransfusion techniques, as appropriate; assisting with wound closure, including administration of sutures and subcutaneous injection of local anesthetics; selecting and applying wound dressings; and providing assistance in securing drainage systems to tissue.[17] Surgical assistants must be familiar with operating room procedures and able to anticipate the needs of the surgeon.[18]

Surgical First Assistants in Statute

Registered nurses licensed under ch. 464, F.S., may serve as surgical first assistants if they are certified in perioperative nursing through a year-long training program fulfilling certain conditions. Such nurses may be reimbursed by insurance companies for their first assistant services at a rate not less than 80 percent of what a physician would be paid for the same services.[19]

Physician assistants may also be reimbursed by insurance companies for surgical first assistant services if they act as substitutes for physicians who would have performed the same services.[20]

National Certification of Surgical First Assistants

AST: Certified Surgical First Assistant
An applicant for the Certified Surgical First Assistant (CSFA) designation must fulfill one of the following:

- Be a graduate of a surgical assistant program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP);
- Hold current certification as a Certified Surgical Technologist from the AST, have participated in at least 350 cases within the last 4 years, and have completed at least 2 full years of surgical first assistant experience; or
- Hold current surgical assistant certification from the NSAA or the American Board of Surgical Assistants (ABSA), have completed 50 hours of AST-approved continuing education within the last 2 years, show proof of operative case experience, and have at least an associate's degree.

Eligible applicants may register to take the CSFA exam offered by the National Board of Surgical Technology and Surgical Assisting (NBSTSA).[21] The NBSTSA was previously known

[17] *Supra* fn. 12.
[18] NSAA, *Scope of Practice*, available at: http://www.nsaa.net/scope_of_practice.php (last visited on April 6, 2013).
[19] Sections 464.027 and 409.906(21), F.S.
[20] Section 627.419(6), F.S.
[21] Edu-Search, *Surgical Technology Certification*, available at: http://www.surgicaltechnologists.net/education/certification (last visited on April 6, 2013).

as the Liaison Council on Certification for the Surgical Technologist (LCCST). After passage of the exam and payment of $290 in fees, an applicant may be certified.[22]

The CSFA certification must be renewed every 4 years either by retaking and passing the initial certification examination or completing 75 hours of continuing education approved by the AST. Recertification by examination costs $499.[23] Recertification by continuing education costs $6 per credit hour for AST members and $400 for non-members.[24]

More than 2,100 people currently hold CSFA certification.[25]

NSAA: Certified Surgical Assistant

Applicants for the Certified Surgical Assistant (CSA) designation must be graduates of approved surgical assistant training programs (there is one in Florida) or provide documentation of 2,250 hours of assisting experience along with several letters of reference from supervising surgeons. Applicants must also pass a multiple-choice examination offered by the NSAA which covers subjects such as anatomy, medical terminology, technical surgical skills, sterile technique, and anesthesia, and pay $400 in fees. Discounts apply for recent graduates and military personnel, and certification by endorsement is available to nurses, physician assistants, and other practitioners under certain conditions.

The CSAs must be recertified every 2 years by completing 50 hours of approved continuing education or retaking and passing the initial certification exam. Recertification fees for NSAA non-members are $700 if via continuing education and $900 if via reexamination. Fees for NSAA members are $100 if via continuing education or reexamination.[26,27]

More than 1,300 people currently hold CSA certification nationally.[28]

ABSA: Surgical Assistant-Certified

To be eligible to for ABSA certification, an applicant must hold at least an associate's degree with a "C" grade or higher in specified college-level courses, have completed an ABSA- or CAAHEP-approved surgical assistant training program, and have passed the ABSA Surgical Assistant-Certified (SA-C) examination. The examination consists of both multiple-choice and practical components and is offered four times per year in Miami, Chicago, New Jersey, and Houston. Payment of a $710 fee is also required.

The SA-C certification must be renewed biennially by retaking and passing the initial certification exam or by completing certain professional development activities. Such activities include reading professional journals, presenting at a hospital seminar, publishing clinical research, and attending medical conferences. Each person must also document participation as a surgical first assistant in either 400 surgical cases or 1,500 procedure hours and hold current

[22] NBSTSA, *CSFA Examination*, available at: http://nbstsa.org/examinations-csfa.html (last visited on April 6, 2013).
[23] NBSTSA, *Renewal Options*, available at: http://nbstsa.org/renewal/index.html (last visited on April 6, 2013).
[24] AST, *Certification*, available at: http://www.ast.org/membership/certification.aspx (last visited on April 6, 2013).
[25] Telephone conversation with NBSTSA staff.
[26] NSAA, *FAQs*, available at: http://nsaa.net/faq.php (last visited on April 6, 2013).
[27] NSAA, *Certification*, available at: http://www.nsaa.net/requirements.php (last visited on April 6, 2013).
[28] Telephone conversation with NSAA staff.

certification in cardiopulmonary resuscitation (CPR), advanced cardiac life support (ACLS), or pediatric advanced life support (PALS). Recertification via examination costs $180, while recertification via professional development costs $100.[29]

More than 1,400 people currently hold active SA-C certification.[30]

III. Effect of Proposed Changes:

The CS amends s. 395.0191, F.S., to add a new subsection concerning surgical technologists and surgical assistants. The CS provides definitions for "certified surgical assistant," "certified surgical technologist," "surgeon," "surgical assistant," and "surgical technologist."

The CS states that a facility may not employ or contract with any person to perform the duties of a surgical assistant or surgical technologist unless that person is a certified surgical assistant or certified surgical technologist. These employment prohibitions do not apply to:

- A person employed or contracted to perform the duties of a surgical technologist or surgical assistant at any time between January 1, 2013, and July 1, 2013;
- Any health care practitioner as defined in ch. 456, F.S., or any student, if the duties performed fall within the scope of the practitioner's or the student's training and practice; or
- Any person enrolled in a surgical technology or surgical assisting training program accredited by CAAHEP, the Accrediting Bureau of Health Education Schools (ABHES), or another accrediting body recognized by the United States Department of Education. Such a person may practice for one year after completion of a training program before he or she is required to be certified.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[29] ABSA, *Candidate Information Booklet and Certification Examination Review Guide 2011-2012*, available at: http://www.absa.net/pdf/ABSA_Guide_2011-2012.pdf (last visited on April 6, 2013).
[30] ABSA, *History and Statistics*, available at: http://www.absa.net/statistics.php (last visited on April 6, 2013).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

People wishing to practice as surgical technologists or surgical first assistants in Florida would be required to pay several hundred dollars in fees required to maintain national certification, unless they fall under one of the CS's exceptions.

B. Private Sector Impact:

Surgical technologists and surgical first assistants who do not meet any of the eligibility requirements in the CS will be unable to practice these occupations at Florida health care facilities. Businesses which offer continuing education courses and examination preparatory courses to surgical technologists and surgical first assistants are likely to receive more business as a result of this CS.

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 Health Policy on April 2, 2013:
The CS redesignates section 1 of the CS as an amendment to ch. 395, F.S., instead of as an undesignated section of law. It also amends the definitions of "surgical assistant" and "surgical technologist" and adds definitions for "certified surgical first assistant," "certified surgical technologist," and "surgeon." The CS amends the employment limitations in the CS to state that health care facilities may not employ or contract with any person *to perform the duties of a surgical assistant or a surgical technologist* unless that person is appropriately certified. The CS also clarifies exceptions to these employment limitations, including for health care practitioners and students for whom surgical technology or surgical assisting services are already within their scope of training and practice and students at surgical technology or surgical assisting training programs accredited by ABHES, CAAHEP, or another accrediting agency recognized by the United States Department of Education.

The CS deletes redundant provisions concerning inspections of health care facilities and rulemaking authority and removes provisions relating to insurance reimbursement of surgical assistant services.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Garcia

588-03416-13 2013360c1

A bill to be entitled

An act relating to surgical assistants and surgical technologists; amending s. 395.0191, F.S.; providing definitions; providing requirements for health care facilities that employ or contract with surgical assistants and surgical technologists; providing exceptions to these requirements; providing an effective date.

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

Section 1. Subsection (11) is added to section 395.0191, Florida Statutes, to read:

395.0191 Staff membership and clinical privileges.—

(11) SURGICAL ASSISTANTS AND SURGICAL TECHNOLOGISTS.—

(a) *Definitions.*—As used in this subsection, the term:

1. "Certified surgical assistant" means a surgical assistant who maintains valid and active one of the following certifications:

a. Certified Surgical First Assistant from the National Board of Surgical Technology and Surgical Assisting.

b. Certified Surgical Assistant from the National Surgical Assistant Association.

c. Surgical Assistant-Certified from the American Board of Surgical Assistants.

2. "Certified surgical technologist" means a surgical technologist who maintains valid and active certification as a Certified Surgical Technologist from the National Board of Surgical Technology and Surgical Assisting.

588-03416-13 2013360c1

3. "Surgeon" means any health care practitioner as defined in chapter 456 whose scope of practice includes performing surgery and who is listed as the primary surgeon in the operative record.

4. "Surgical assistant" means a person who provides aid under the supervision of a surgeon in exposure, hemostasis, closures, and other intraoperative technical functions and assists the surgeon in performing a safe operation with optimal results for the patient.

5. "Surgical technologist" means a person who assists and practices under the supervision of a surgeon to ensure that the operating room environment is safe, that proper equipment is available, and that the operative procedure is conducted efficiently. Surgical technologist duties include, but are not limited to, maintaining sterility during a surgical procedure, handling and ensuring the availability of necessary equipment and supplies, and maintaining visibility of the operative site.

(b) *Employment limitations.*—

1. A facility may not employ or contract with any person to perform the duties of a surgical assistant unless the person is a certified surgical assistant.

2. A facility may not employ or contract with any person to perform the duties of a surgical technologist unless the person is a certified surgical technologist.

3. Subparagraphs 1. and 2. do not apply to:

a. A person who was employed or contracted to perform the duties of a surgical technologist or a surgical assistant at any time between January 1, 2013, and July 1, 2013.

b. A health care practitioner as defined in chapter 456 or

a student if the duties he or she performs fall within the scope of the practitioner's or the student's training and practice.

c. A person enrolled in a surgical technology or surgical assisting training program accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools, or another accrediting body recognized by the United States Department of Education on July 1, 2013. A person may practice as a surgical technologist or a surgical assistant for 1 year after completion of such a training program before he or she is required to meet the criteria in subparagraphs 1. or 2.

Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4-9-13
Meeting Date

Topic Surgical Technologist Surgical First Assist Bill Number SB 360 *(if applicable)*

Name Kathy Zorn Amendment Barcode _____ *(if applicable)*

Job Title Surgical First Assistant

Address 700 Eleazer PL Phone 510-7256
Street

Tallahassee, FL 32312 E-mail kjaw1@aol.com
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Surgical Assistant 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

4-19-2013 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Surgical Technologist & Surgical Assistant Bill Number SB 360 *(if applicable)*

Name Shannon E. Smith Amendment Barcode *(if applicable)*

Job Title Chair, CST

Address Tallahassee Community College Phone 706-540-6779

Street

Tallahassee Fla 32

City *State* *Zip*

E-mail ssmith@tcc.edu

Speaking: [X] For [ ] Against [ ] Information

Representing Association of Surgical Assistants

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.

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

4-9-2013 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Surgical Technologist & Surgical Assistant Bill Number SB 360 *(if applicable)*

Name Libby (Mary E.) McNaron Amendment Barcode *(if applicable)*

Job Title PRESIDENT Florida Association of Surgical Technologist

Address 2004A Firetower Rd Phone 850-873-3551

Street

Chipley FLA 32428 E-mail lmcnaron@gulfcoast.edu

City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing FLORIDA STATE ASSEMBLY SURGICAL TECHNOLOGIST

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

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 Committee on Banking and Insurance

BILL:	SPB 7152
INTRODUCER:	For consideration by the Committee on Banking and Insurance
SUBJECT:	Motor Vehicle Liability Insurance
DATE:	April 7, 2013 REVISED:

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

I. Summary:

SPB 7152 revises the financial responsibility and security requirements that apply to every owner or operator of a motor vehicle registered in Florida. Under the bill, each registrant must comply with the requirement to maintain bodily injury liability (BI) coverage. The bill requires a driver to maintain the ability to respond in damages for the driver's liability from a motor vehicle accident in the following amounts:

- Property Damage – At least $10,000 in any one crash.
- Bodily Injury - $25,000 for bodily injury or death in any one crash and $50,000 for bodily injury or death of two or more persons in any one crash (subject to the $25,000 limit on an individual).

SPB 7152 repeals the Florida Motor Vehicle No-Fault Law, effective January 1, 2014, at which point personal injury protection coverage will no longer be required. Motor vehicle insurance policies issued or renewed on or after January 1, 2014, may not include PIP. A policy issued prior to January 1, 2014, that provides PIP coverage but lacks the required BI coverage is deemed to meet the financial responsibility and security requirements until the policy is renewed or cancelled. Such policies will provide PIP benefits to the insured. Insurers must allow each insured to change his or her policy to add the required bodily injury coverage and eliminate PIP coverage on or after January 1, 2014.

Other provisions of the bill include:

- Provides that a policy with at least $60,000 in combined property damage and bodily injury liability coverage satisfies the financial responsibility requirements;
- Requires a deposit of $60,000 in cash, securities, or trust funds with the DHSMV in order to obtain a certificate of deposit from the department that satisfies proof of financial responsibility requirements.
- Authorizing electronic proof of insurance and specifying that presenting an electronic device to law enforcement does not constitute consent to otherwise search the device;
- Requiring insurers to report to the Department of Highway Safety and Motor Vehicles (DHSMV) the issuance of a new BI or PD motor vehicle policy within 10 days;
- Increases license and registration reinstatement fees;
- Eliminates the ability of an owner or operator of a motor vehicle (other than a for-hire transportation vehicle) to meet financial responsibility requirements by posting a surety bond with the DHSMV;
- Revises the option to prove financial responsibility by furnishing a certificate of self-insurance showing a deposit of cash or securities;
- Revises the requirements for qualifying as a self-insurer for purposes of satisfying financial responsibility;
- Require motorcycles to comply with financial responsibility requirements; and
- Specifies that all suspensions for failure to maintain required security as required by law prior to January 1, 2014, remain in full force and effect after that date.

The effective date of the bill is January 1, 2014, except as otherwise specified.

This bill substantially amends the following sections of the Florida Statutes: 316.646, 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 324.011, 324.021, 324.022, 324.0221, 324.023, 324.031, 324.071, 324.161, 324.171, 400.9905, 400.991, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 626.989, 626.9895, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.732, 627.733, 627.734, 627.7401, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234.

The bill repeals the following sections of the Florida Statutes: 627.730, 627.731, 627.7311, 627.736, 627.737, 627.739, 627.7403, 627.7405, 627.7407

The bill creates the following section of the Florida Statutes: 627.7355

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the Florida Motor Vehicle No-Fault Law (No-Fault law)[1], owners or registrants of motor vehicles are required to purchase personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault.[2] Policyholders are indemnified by their own

[1] Sections 627.730-627.7405, F.S.
[2] Section 627.733, F.S.

insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault.[3] 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.[4] 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.[5] The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person who sustains an emergency medical condition, which is reduced to a $2,500 limit for medical benefits if a treating medical provider determines an emergency medical condition did not exist.[6] Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses,[7] 60 percent of loss of income,[8] 100 percent of replacement services,[9] 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.[10]

PIP Medical Benefits

The 2012 Legislature revised the provision of Personal Injury Protection medical benefits under the Florida Motor Vehicle No-Fault Law, effective January 1, 2013.[11] To receive PIP medical benefits, insureds must receive initial services and care within 14 days after the motor vehicle accident.[12] Initial services and care are only reimbursable if lawfully provided, supervised, ordered or prescribed by a licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider.[13] Follow up services and care requires a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.[14]

Personal Injury Protection medical benefits now have two different coverage limits, based upon the severity of the medical condition of the individual. An insured may receive up to $10,000 in medical benefits for services and care if a physician, osteopathic physician, dentist, physician's assistant or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition.[15] An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of

[3] See s. 627.731, F.S.
[4] Section 627.737, F.S.
[5] See sections 324.022, F.S. and 627.733, F.S.
[6] Section 627.736(1), F.S.
[7] Section 627.736(1)(a), F.S.
[8] Section 627.736(1)(b), F.S.
[9] Id.
[10] Section 627.736(1)(c), F.S.
[11] Chapter 2012-197, L.O.F. (CS/CS/HB 119)
[12] Section 627.736(1)(a), F.S.
[13] Section 627.736(1)(a)1., F.S.
[14] Section 627.736(1)(a)2., F.S.
[15] Section 627.736(a)(a)3., F.S.

immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.[16] If a provider who rendered treatment or services determines that the insured did not have an emergency medical condition, the PIP medical benefit limit is $2,500.[17] Massage and acupuncture are not reimbursable, regardless of the type of provider rendering such services.[18]

The $5,000 PIP death benefit is provided in addition to medical and disability benefits, effective January 1, 2013. Previously, the death benefit was the lesser of the unused PIP benefits, up to a limit of $5,000.

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 services supplies and care provided by ambulatory surgical centers and clinical laboratories, 200 percent of Medicare Part B;
- For durable medical equipment, 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B;
- For all other medical services, supplies, and care, 200 percent of the participating physicians fee schedule 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.[19] Also, the insurer must reimburse a health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent copayment) or for amounts that exceed maximum policy limits.[20]

[16] Section 627.732(16), F.S.
[17] Section 627.736(1)(a)4., F.S.
[18] Section 627.736(a)(a)5., F.S.
[19] Section 627.736(5)(a)3., F.S.
[20] Section 627.736(5)(a)4., F.S.

CS/CS/HB 119 revised the PIP medical fee schedule in an effort to resolve alleged ambiguities that led to conflicts and litigation between claimants and insurers. The bill clarified the reimbursement levels for care provided by ambulatory surgical centers and clinical laboratories and for durable medical equipment. The bill also provided that Medicare fee schedule in effect on March 1 is applicable for the remainder of that year.[21] Insurers are authorized to use Medicare coding policies and payment methodologies of the Centers for Medicare and Medicare Services, including applicable modifiers, when applying the fee schedule if they do not constitute a utilization limit.[22] The bill also requires insurers to include notice of the fee schedule in their policies.[23]

Attorney Fees

Section 627.428, F.S., requires an insurer to pay the insured's or beneficiary's reasonable attorney fees upon a judgment against the insurer and in favor of the insured or named beneficiary under an insurance policy, and applies to disputes under the No-Fault Law.[24] CS/CS/HB 119 amended provisions related to attorney fee awards in No-Fault disputes. The bill prohibits the application of attorney fee multipliers.[25] The bill also requires that the attorney fees awarded must comply with prevailing professional standards, not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity, and represent legal services that are reasonable to achieve the result obtained.[26] The offer of judgment statute, s. 768.79, F.S., is applied to No-Fault cases, providing statutory authority for insurers to recover fees if the plaintiff's recovery does not exceed the insurer's settlement offer by a statutorily specified percentage.[27]

Mandatory Rate Filings and Data Call

CS/CS/HB 119 required the Office of Insurance Regulation to contract with a consulting firm to calculate the expected savings from the act.[28] The OIR retained Pinnacle Actuarial Resources, Inc., which released an August 20, 2012, report estimating an indicated statewide average savings in PIP premiums of 14 percent to 24.6 percent and an average overall motor vehicle insurance premium reduction ranging from 2.8 percent to 4.9 percent.[29] The report noted that if insurers' current PIP rates were inadequate they would likely offset the savings from CS/CS/HB 119 against their indicated PIP rates. By October 1, 2012, each insurer writing private passenger automobile personal injury protection insurance was required to submit a rate filing providing at least a 10 percent reduction of its PIP rate or explain in detail its reasons for failing to achieve those savings. According to information provided by the OIR, 10 of the 25 largest motor vehicle insurers achieved a 10 percent reduction in PIP premiums. The weighted average of the PIP premium reduction of these carriers was approximately 2 percent.

[21] Section 627.736(5)(a)2., F.S.
[22] Section 627.736(5)(a)3., F.S.
[23] Section 627.736(5)(a)5., F.S.
[24] Section 627.736(8), F.S.
[25] See id.
[26] See id.
[27] See id.
[28] Section 15, Ch. 2012-197, L.O.F.
[29] Pinnacle Actuarial Resources, Inc., *Impact Analysis of HB 119*, (Aug. 20, 2012).

A second rate filing must be made by January 1, 2014, that provides at least a 25 percent reduction of the insurer's July 1, 2012, PIP rate or explain in detail its reasons for failing to achieve those savings. The Office of Insurance Regulation must order an insurer to stop writing new PIP policies if the insurer requests a rate in excess of the statutorily required rate reduction and fails to provide a detailed explanation for that failure. The Office of Insurance Regulation must perform a comprehensive PIP data call and publish the results by January 1, 2015.[30] The data call will analyze the impact of the act's reforms on the PIP insurance market.

Motor Vehicle Insurance Fraud

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 three-year amount was nearly doubled by the 7,748 PIP fraud referrals received by the division during the 2011/2012 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. CS/CS/HB 119 contained numerous provisions designed to curtail PIP fraud. A health care practitioner found guilty of insurance fraud under s. 817.234, F.S., loses his or her license for 5 years and may not receive PIP reimbursement for 10 years. Insurers are provided an additional 60 days (90 total) to investigate suspected fraudulent claims, however, an insurer that ultimately pays the claim must also pay an interest penalty.[31] All entities seeking reimbursement under the No-Fault Law must obtain health care clinic licensure except for hospitals, ambulatory surgical centers, entities owned or wholly owned by a hospital, clinical facilities affiliated with an accredited medical school and practices wholly owned by a physician, dentist, or chiropractic physician or by such physicians and specified family members.[32] The bill also defined failure to pay PIP claims within the time limits of s. 627.736(4)(b), F.S., as an unfair and deceptive practice.

[30] Section 16, Ch. 2012-197, L.O.F.
[31] Section 627.736(4)(i), F.S.
[32] Section 627.736(5)(h), F.S.

Financial Responsibility Law

Florida's financial responsibility law requires proof of ability to pay monetary damages for bodily injury and property damage liability arising out of a motor vehicle accident or serious traffic violation.[33] The owner and operator of a motor vehicle need not demonstrate financial responsibility, i.e., obtain BI and PD coverages, until *after the accident*.[34] At that time, a driver's financial responsibility is proved by the furnishing of an active motor vehicle liability policy. The minimum amounts of liability coverages required are $10,000 in the event of bodily injury to, or death of, one person, $20,000 in the event of injury to, or death of, two or more persons, and $10,000 in the event of damage to property of others, or $30,000 combined BI/PD policy.[35] The driver's license and registration driver who fails to comply with the security requirement to maintain PIP and PD insurance coverage is subject to suspension.[36] A driver's license and registration may be reinstated by obtaining a liability policy and by paying a fee to the Department of Highway Safety and Motor Vehicles.[37]

Review of Auto Insurance Systems

Two auto insurance systems are utilized throughout the country: the tort system and the no-fault system, with certain variations. Thirty-eight states utilize the tort system in which the at-fault party is liable for damages (medical, economic, property damage and pain and suffering) to other parties in the accident.[38] Parties seeking redress for their injuries do so from the at-fault driver, and must prove negligence on the part of that individual. Nine of the 38 tort states, known as "add-on" states, require auto insurers to offer PIP coverage, but unlike no-fault states, do not restrict the right to pursue a liability claim or lawsuit.[39] Benefits are generally either offered in a PIP coverage form similar to that in no-fault states or as additional wage replacement benefits to medical payments coverage. Three tort add-on states require the purchase of PIP coverage; six do not, but require insurers to offer PIP coverage.

Twelve states (including Florida) have a no-fault system and mandate first party PIP coverage for medical benefits, wage loss, and death benefits, with a limitation on pain and suffering lawsuits.[40] All 12 jurisdictions take different approaches to no-fault legislation in that coverage amounts, deductibles, mandated coverages, tort thresholds for pain and suffering claims and the use of fee schedules or treatment protocols, vary widely among these entities. Each state has either a "verbal" or "monetary" threshold regarding the seriousness of a person's injuries that must be met prior to the filing of a tort suit for noneconomic damages against an at-fault driver. Florida and the four most populous no-fault states use a verbal threshold, which is a statutory

[33] See Chapter 324, F.S.
[34] Section 324.011, F.S.
[35] Section 324.022, F.S.
[36] Section 324.0221(2), F.S.
[37] Section 324.0221(3), F.S.
[38] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
[39] Arkansas, Delaware, Maryland, Oregon, South Dakota, Texas, Virginia, Washington, and Wisconsin.
[40] Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Pennsylvania, and Utah are the other No-Fault states.

description of the severity of an injury. The seven remaining no-fault states have monetary thresholds ranging from $1,000 to $5,000. Three of the 12 no-fault states (Kentucky, New Jersey and Pennsylvania) are known as "choice" states and offer consumers a choice between purchasing PIP coverage or traditional tort liability coverage which does not include PIP benefits.

Auto Coverage Requirements

Forty-eight states require car owners to buy a minimum amount of bodily injury liability (BI) and property damage liability (PD) insurance coverage before they can legally drive their vehicles.[41] Further, all states have financial responsibility laws which require persons involved in auto accidents (or serious traffic infractions) to furnish proof of BI and PD liability insurance. The minimum coverage amounts vary among the states. Florida has a requirement for bodily liability coverage for persons subject to the Financial Responsibility Law of $10,000 per person, $20,000 per accident, and $10,000 in the event of damage to property of others, or a $30,000 combined (BI/PD) single limit. A Florida driver is not required to maintain BI coverage until he or she is involved in a crash or convicted of certain traffic offenses

Tort-Based Motor Vehicle Insurance Jurisdictions

In a tort-based liability system, auto injury claimants seek payment from the at-fault driver for both economic and non-economic damages from dollar one. A tort-based system represents a more traditional legal philosophy of holding persons responsible for injuries caused by their negligent operation of a vehicle. In theory, this encourages safer operation of automobiles and is generally viewed by the public as consistent with the concept of personal responsibility.

If Florida repeals PIP and mandates BI coverage, it will be important for drivers to appreciate coverage applications under the tort system. For the most common type of accident (with one party at-fault), the at-fault party's BI coverage would pay for injuries to the not at-fault driver, unless the at-fault party was uninsured. If the at-fault party is uninsured (or underinsured), the not at-fault party would utilize his/her UM coverage, if purchased, to pay for injuries sustained in an accident. The at-fault party's PD coverage would compensate for physical damages to the not at-fault driver's vehicle. If the not-at-fault party has Med Pay coverage, it can be used to cover his or her own medical expenses, which could then be subrogated into the BI claim by the not at-fault driver's insurer.

With respect to the at-fault party, that driver's own health insurance, if available, would cover his or her own expenses. Med Pay coverage, if purchased, would pay for his/her medical expenses up to the Med Pay limits, at which point health insurance would apply. In the event the at-fault party did not have health insurance, then the medical costs would not be reimbursed and the individual would be responsible for these costs or such costs would be assumed by the health care provider.

[41] New Hampshire does not require auto insurance if the driver complies with alternative financial responsibility requirements. Florida only requires BI coverage after a driver is involved in a crash.

For single car accidents, the driver of the vehicle is presumed to be the at-fault party and therefore will be essentially in the same situation as the at-fault party described above. Occupants in the vehicle can sue the driver of the vehicle for their injuries and are in a similar circumstance to the not at-fault party's situation, previously described. Family members are precluded from suing the driver because of the intra-family exclusion due to the fact that only non-family occupants can pursue a tort claim. Pedestrians who are injured in an accident are in a similar situation as the not at-fault party.

III. Effect of Proposed Changes:

Motor Vehicle Financial Responsibility Law

Section 1. Amends s. 316.646, F.S., to authorize electronic proof of insurance and specify that presenting an electronic device to law enforcement does not constitute consent to otherwise search the device. The officer is not responsible for any damage to the device. DHSMV must adopt rules to administer the proof of insurance requirements.

Section 2. Amends s. 324.011, F.S., to revise the purpose of the motor vehicle financial responsibility law.

Section 3. Amends s. 324.021, F.S., to amend the definition of "proof of financial responsibility" to mean the ability to respond in damages for liability in the amount of $25,000 for bodily injury or death to another and, subject to the $25,000 limit for one person, in the amount of $50,000 for bodily injury or death of two or more people in one crash.

Section 4. Amends s. 324.022, F.S., to revise the financial responsibility requirements that apply to every owner or operator of a motor vehicle registered in Florida. Under the bill, each registrant of a motor vehicle must maintain BI coverage and PD coverage. Under current law, BI coverage is required once the operator of a motor vehicle is involved in a crash or convicted of certain traffic offenses (such as driving under the influence). The bill requires a driver to maintain the ability to respond in damages for the driver's liability from a motor vehicle accident in the following amounts:

- Property Damage – At least $10,000 in any one crash.
- Bodily Injury - $25,000 for bodily injury or death in any one crash and $50,000 for bodily injury or death of two or more persons in any one crash (subject to the $25,000 limit on an individual).

The financial responsibility requirements may be met by maintaining an insurance policy providing coverage in at least the minimum mandatory amounts for property damage coverage and bodily injury liability coverage. A policy that provides at least $60,000 for combined property damage and bodily injury liability also satisfies the financial responsibility requirements.

Under current law, all owners and operators of private passenger motor vehicles are required to maintain:

- Property Damage – At least $10,000 in any one crash.
- Personal Injury Protection – At least $10,000 for a first-party insured and $20,000 for two or more first-party insureds (subject to the $10,000 limit on an individual).
- The operator of a motor vehicle who is involved in a crash must subsequently show proof of financial responsibility to pay for bodily injury damages in future crashes in at least $10,000 for bodily injury or death in one crash and $20,000 for bodily injury or death of two or more persons in one crash (subject to the $10,000) limit on liability.

The financial responsibility requirements may be met by maintaining an insurance policy providing coverage in at least the minimum mandatory amounts. A policy providing at least $30,000 in combined property damage and bodily injury liability coverage meets the requirement for property damage liability coverage.

Section 5. Amends s. 324.0221, F.S., to require insurers to report to the DHSMV the issuance of a new BI or PD motor vehicle policy within 10 days. Under current law, the insurer has 30 days to report a new PIP or PD policy to the department.

Section 6. Amends s. 324.023, F.S, regarding the financial responsibility requirements for owners or operators who commit a DUI, to conform to the elimination of posting a bond as a means of complying with the financial responsibility laws.

Section 7. Amends s. 324.031, F.S., to eliminate the ability of an owner or operator of a motor vehicle (other than a for-hire transportation vehicle) to meet financial responsibility requirements by posting a surety bond with the DHSMV. Representatives from the DHSMV recommend the deletion of this option because it is not currently used.

This section also revises the option to prove financial responsibility by furnishing a certificate of self-insurance showing a deposit of cash or securities, by requiring a deposit of $60,000 for each vehicle owned, up to a maximum of $240,000. Current law requires a deposit of $30,000 for each vehicle owned, up to a maximum of $120,000. Increasing the deposit requirements reflects the $25,000/$50,000 BI requirement imposed by the bill, which is higher than $10,000/$20,000 PIP requirement under current law.

Section 8. Amends s. 324.071, F.S., to revise the amount of license or registration reinstatement fees, from $15 to the amounts specified in s. 324.0221, F.S., ($150 for the first reinstatement, $250 for the second, and $500 for any subsequent reinstatement).

Section 9. Amends s. 324.161, F.S., to require a deposit of $60,000 in cash, securities, or trust funds with the DHSMV in order to obtain a certificate of deposit from the department that satisfies proof of financial responsibility requirements. Current law requires a $30,000 deposit. Increasing the deposit requirements reflects the $25,000/$50,000 BI requirement imposed by the bill, which is higher than $10,000/$20,000 PIP requirement under current law.

Section 10. Amends s. 324.171, F.S., to revise the requirements for qualifying as a self-insurer for purposes of satisfying financial responsibility. A private individual with private passenger vehicles must have a net unencumbered worth of at least $60,000. Current law requires an unencumbered net worth of $40,000. A person such as a firm, partnership, association, corporation who is not a natural person must possess a net unencumbered worth of at least $60,000 for the first motor vehicle ($40,000 in current law) and $30,000 for each additional motor vehicle ($20,000 in current law) or maintain sufficient net worth, as determined by the DHSMV, to be financially responsible for losses. Increasing the net worth requirement reflects the $25,000/$50,000 BI requirement imposed by the bill, which is higher than $10,000/$20,000 PIP requirement under current law.

Repeal of the Florida Motor Vehicle No-Fault Law and Revision of Security Requirements

Section 11. Repeals s. 627.730, F.S., which names ss. 627.730-627.7405, F.S., the "Florida Motor Vehicle No-Fault Law."

Section 12. Repeals s. 627.731, F.S., which provides the purpose of the Florida Motor Vehicle No-Fault Law.

Section 13. Repeals s. 627.7311, F.S., which includes the provisions of the Florida Motor Vehicle No-Fault Law in all motor vehicle insurance policies, regardless of their express inclusion.

Section 14. Amends s. 627.732, F.S., to repeal definitions unique to provisions of the Florida Motor Vehicle No-Fault law that govern personal injury protection coverage. The bill retains definitions for terms used in ss. 627.733 – 627.7355, F.S., relating to the security requirements placed on owners and registrants of motor vehicles.

The definition of "motor vehicle" is retained and amended to delete language limiting the term to self-propelled vehicles with four or more wheels. The revision of this definition will require motorcycles to comply with security requirements, likely by obtaining an insurance policy that provides bodily injury and property damage liability coverages in at least the limits required by s. 324.022, F.S. The bill retains definitions of "private passenger motor vehicle," "commercial motor vehicle," "owner," and "knowingly."

Section 15. Amends s. 627.733, F.S., to revise the required security that each owner or registrant of a motor vehicle (other than a school bus or limousine) must maintain. The owner or registrant must maintain the security required by s. 324.022, F.S., which is the ability to respond in damages for at least $10,000 for property damage and $25,000 for bodily injury incurred by one person and subject to the individual BI limit, $50,000 for bodily injury incurred by more than one person. The section eliminates the requirement that drivers must maintain personal injury protection.

Section 16. Amends s. 627.734, F.S., to conform the proof of security requirements to the repeal of the Florida Motor Vehicle No-Fault Law and the requirement to maintain bodily injury liability coverage.

Section 17. Amends s. 627.7401, F.S., and renumbers it as s. 627.7341, F.S., to require the Financial Services Commission to adopt a form to notify insureds of the security requirements of s. 627.733, F.S., and the proof of security requirement under s. 627.734. The notice must describe the benefits provided by bodily injury liability coverage and property damage liability coverage. Under current law, the notice serves to notify insureds of their right to receive PIP benefits.

Section 18. Creates s. 627.7355, F.S., which requires all claims arising out of the plaintiff's injuries in any action for which security has been provided as required (PD coverage with limits of at $10,000 and BI coverage with limits of at least $25,000/$50,000) to be brought together. This is currently required for actions brought under the No-Fault law in s. 627.736(15), F.S.

Section 19. Repeals s. 627.736, F.S., which sets forth the benefits provided by personal injury protection coverage, the procedure for payment of PIP benefits, the PIP fee schedule, discovery of facts about an injured person under PIP, mental and physical examinations, attorney fees, demand letters and other provisions.

Section 20. Repeals s. 627.737, F.S., which contains the tort exemption for damages payable by PIP and the "verbal threshold" that limits the ability of a plaintiff to recover tort damages for pain and suffering.

Under the current No-Fault law, an at-fault driver is not liable for the bodily injury or death of another person up to the $10,000 PIP policy limit. The at-fault driver is responsible for damages in excess of the PIP policy limit. Current law also prohibits recovery of pain and suffering damages unless the injury or disease caused by the at-fault driver results in death, significant and permanent loss of an important body function, permanent injury within a reasonable degree of medical probability (other than scarring or disfigurement), or significant and permanent scarring or disfigurement.

Section 21. Repeals s. 627.739, F.S., which governs the deductibles that may apply to personal injury protection and how the deductible is applied. Current law requires insurers to offer deductibles of $200, $500, and $1,000.

Section 22. Repeals s. 627.7403, F.S., which requires mandatory joinder of derivative claims. A similar provision is created in s. 627.7355, F.S., by Section 26 of the bill.

Section 23. Repeals s. 627.7405, F.S., which details insurers' right of reimbursement under the Florida Motor Vehicle No-Fault Law.

Section 24. Repeals s. 627.7407, F.S., which specifies how to apply Florida Motor Vehicle No-Fault Law in the aftermath of the re-enactment of the law on January 1, 2008.

Section 25. Repeals s. 15 and s. 16 of chapter 2012-197, Laws of Florida. Section 15 requires insurers to make rate filings that provide specified premium reductions or provide a detailed explanation why the premium reduction cannot be provided. Section 16 requires the Office of Insurance Regulation to perform a PIP data call and publish the results by January 1, 2015.

Technical Changes

Sections 26-57. Makes technical and conforming changes to the following statutes: 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 400.9905, 400.991, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 626.989, 626.9895, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234, F.S.

Application of Bill

Section 58. Specifies how the provisions of the bill will be applied and requires insurers to provide notice to policyholders regarding the repeal of the Florida Motor Vehicle No-Fault Law and the requirement to maintain security for bodily injury liability. The bill will be applied as follows:

- Effective January 1, 2014, any person subject to the financial responsibility requirements of s. 324.022, F.S., and the security requirements of s. 627.733, F.S., must maintain "minimum security requirements" of at least:
  - $10,000 related to property damage of others caused by an insured.
  - $25,000 related to bodily injury of one person caused by an insured.
  - $50,000 related to bodily injury of more than one person caused by the insured, subject to the $25,000 limit on an individual.
- Effective January 1, 2014, all new and renewal motor vehicle policies must provide property damage coverage with limits of at least $10,000 and bodily injury coverage with limits of at least $25,000/$50,000.
- On or after January 1, 2014, an existing motor vehicle policy issued prior to that date that provides PIP and PD coverage that met the requirements of s. 324.022, F.S., and s. 627.733, F.S., on December 31, 2013, but subsequently will not meet minimum security requirements (because it lacks the necessary BI coverage) shall be deemed to meet the security requirements of s. 627.022, F.S., and s. 627.733, F.S., until the policy is renewed, nonrenewed, or cancelled on or after January 1, 2014.
- Each insurer must allow each insured to change his or her policy to add the required bodily injury coverage and eliminate PIP coverage. The insurer may not charge an additional fee to the policyholder that is applicable solely to a change in coverage, however, this may not be interpreted to prevent the insurer from charging an appropriate additional premium.
- All motor vehicle insurance policies issued or renewed on or after January 1, 2014, may not include PIP.
- No later than September 1, 2013, each motor vehicle insurer must provide notice of the provisions of this section to each insured.

This section is effective upon the act becoming law.

Existing Suspensions for Failure to Maintain Security

Section 59. Specifies that all suspensions for failure to maintain required security as required by law prior to January 1, 2014, remain in full force and effect after that date.

Effective Date

Section 60. Except as otherwise provided, the act is effective January 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

In *Myers v. McCarty*, Case No. 2013-CA-73 (Fla. 2nd Cir.), the Court granted a temporary injunction against the provisions of chapter 2012-197, L.O.F., which require a finding of an emergency medical condition as a prerequisite for the payment of PIP benefits or that prohibit the payment of benefits for services provided by acupuncturists, chiropractors, and massage therapists. In the Order Granting in Part Motion for Temporary Injunction, the Court found that the No-Fault law likely violates the constitutional right of access to the courts found in Article I, Section 21 of the Florida Constitution. The Court noted that the No-Fault law limits the right of a person injured in a motor vehicle accident to seek redress in the courts, but had been previously found by the Florida Supreme Court to be a "reasonable alternative" to the common law tort system.[42] The injunction was granted because the Court determined that the provisions requiring determination of an emergency medical condition prior to receiving PIP benefits and prohibiting reimbursement of certain types of treatment resulted in a No-Fault system that does not provide a reasonable alternative to the remedies available under common law. A Notice of Appeal of the temporary injunction was filed with the Court on March 21, 2013, which constitutes an automatic stay of the circuit court's order pursuant to Rule 9.310(b)(2), Florida Rules of Appellate Procedure.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The SPB increases the fees for reinstatement of driver's licenses and motor vehicle registrations. Under current law, a $15 fee must be paid to during reinstatement. Under the SPB, the fees are $150 for the first reinstatement, $250 for the second, and $500 for any subsequent reinstatement.

[42] Lasky v. State Farm Ins. Co., 296 So.2d 9 (Fla. 1974).

B. Private Sector Impact:

Repealing No-Fault and returning to a tort system eliminates the requirement that motorists purchase PIP and that insurers provide this coverage, replacing it with a requirement to purchase bodily injury coverage. Insureds who currently have BI coverage with limits of at least $25,000/$50,000 should pay a lower premium due to the removal of PIP coverage from the policy.

Representatives from the OIR have provided the Banking and Insurance Committee with calculations of the premium impact of repealing No-Fault and mandating $25,000/$50,000 in BI liability coverage for various types of drivers with five sample insurance companies[43] in seven locations[44] of the state.[45] The OIR calculations that policyholders that currently have "full coverage"[46] including BI coverage of at least $25,000/$50,000 should see a premium reduction ranging from approximately 3.2 percent to 11.2 percent.

Insureds who currently purchase the minimum required PIP and PD coverages but do not have BI coverage generally will incur increases through the bill, though drivers in densely populated locations that have high amounts of PIP-related fraud may pay lower premiums. A review of the OIR calculations shows that the highest PIP premiums are in densely populated areas that have historically experienced high levels of PIP-related fraud such as Central Tampa and Central Miami. Representatives from the OIR indicate that approximately 90 percent of Florida insureds have BI coverage.

Another effect of switching to a tort system is that loss costs currently attributable to PIP will be absorbed by other coverages. A 2007 study by Pinnacle Actuarial Services (Pinnacle) estimated that 79.5 percent of prior PIP losses would be transferred to other coverages within the auto insurance system, losses shifting into the health care system would be 16.4 percent, while 4.1 percent of losses would not be covered by any type of insurance.

C. Government Sector Impact:

The OIR will likely experience an increase in its workload related to motor vehicle insurance form and rate filings due to the repeal of PIP and the creation of a BI mandate. Eliminating the comprehensive PIP data call and report that the OIR must publish by January 1, 2015, may reduce the workload of the office.

The fees for reinstatement of driver's licenses and registrations collected by the DHSMV will increase. The proposed bill is unlikely to have any other financial impact on the department.

[43] Allstate Fire & Casualty, Direct General, GEICO General, Progressive American, and State Farm.
[44] Central Fort Lauderdale, Central Jacksonville, Pensacola, Central Tampa, Tallahassee, Central Miami, and Central Florida.
[45] Office of Insurance Regulation, *OIR Presentation on Personal Injury Protection*, (April 2. 2013). On file with the Banking and Insurance Committee.
[46] Full coverage includes PIP, BI, PD, Uninsured Motorist, Medical Payments, Collision, and Comprehensive coverages.

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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-03046B-13 20137152__

A bill to be entitled

An act relating to motor vehicle liability insurance; amending s. 316.646, F.S.; authorizing the use of an electronic device to provide proof of insurance; authorizing the Department of Highway Safety and Motor Vehicles to adopt rules; amending s. 324.011, F.S.; revising legislative intent with respect to financial responsibility for the damages caused by the operation of a motor vehicle; amending ss. 324.021 and 324.022, F.S.; increasing financial responsibility limits with respect to bodily injury or death; conforming provisions to changes made by the act; amending s. 324.0221, F.S.; requiring insurers to submit information to the Department of Highway Safety and Motor Vehicles and to notify insureds about bodily injury insurance rather than personal injury protection coverage; amending s. 324.023, F.S.; conforming a cross-reference; amending s. 324.031, F.S.; deleting the requirement that the owner of a for-hire vehicle post a bond to prove financial responsibility; increasing the financial responsibility limits for motor vehicle liability; amending s. 324.071, F.S.; conforming provisions to changes made by the act; amending s. 324.161, F.S.; increasing the amount required for a surety bond or deposit; amending s. 324.171, F.S.; revising the required threshold limit for self-insurers; repealing s. 627.730, F.S., providing citation to the Florida

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Motor Vehicle No-Fault Law; repealing s. 627.731, F.S., relating to the purpose of the No-Fault Law; repealing s. 627.7311, F.S., relating to the effect of law on personal injury protection policies; amending s. 627.732, F.S.; deleting definitions relating to the no-fault law; amending s. 627.733, F.S.; deleting security requirements with respect to no-fault coverage to substitute security requirements under ch. 324, F.S.; amending s. 627.734, F.S.; conforming cross-references; renumbering and amending s. 627.7401, F.S.; applying notice requirements to bodily injury and property damage liability security instead of personal injury protection; creating s. 627.7355, F.S.; requiring all claims relating to personal injury to be brought in a single action; repealing s. 627.736, F.S., relating to personal injury protection benefits; repealing s. 627.737, F.S., relating to exemption from tort liability for persons maintaining personal injury protection coverage; repealing s. 627.739, F.S., relating to personal injury protection deductibles; repealing s. 627.7403, F.S., relating to the mandatory joinder of derivative claims; repealing s. 627.7405, F.S., relating to the insurers' right of reimbursement; repealing s. 627.7407, F.S., relating to the application of the No-Fault Law; repealing ss. 15 and 16 of chapter 2012-197, Laws of Florida, requiring the Office of Insurance Regulation to contract for a study and perform a data call relating to changes made to the No-Fault Law in 2012; amending

ss. 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 400.9905, 400.991, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 626.989, 626.9895, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234 F.S.; conforming provisions to changes made by the act by removing references to personal injury protection and the Florida Motor Vehicle No-Fault Law; making technical changes; conforming cross-references; providing for the termination of personal injury protection policies and the requirement for maintaining minimum security requirements that allow a person to respond to property damage and bodily injury by a certain date; requiring the insurer to notify the insured about such changes by a certain date; providing for applicability of suspensions for failure to maintain security; providing effective dates.

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

Section 1. Subsection (1) of section 316.646, Florida Statutes, is amended, and subsection (5) is added to that section, 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 and~~, required by s. 324.023 to maintain~~ liability security for bodily injury or death must~~, or~~

~~required by s. 627.733 to maintain personal injury protection security on a motor vehicle shall~~ have in his or her immediate possession at all times while operating a ~~such~~ motor vehicle proper proof of maintenance of the required security.

(a) Such proof must ~~shall~~ be in a uniform paper or electronic format, as ~~proof of insurance card in a form~~ prescribed by the department, or a valid insurance policy, an insurance policy binder, a certificate of insurance, or such other proof as may be prescribed by the department.

(b) The act of presenting to a law enforcement officer an electronic device that displays proof of insurance in an electronic format does not constitute consent for the officer to access any other information on the device. The person who presents the device to the officer assumes liability for any resulting damage to the device.

(5) The department shall adopt rules to administer this section.

Section 2. Section 324.011, Florida Statutes, is amended to read:

324.011 Legislative intent and purpose ~~of chapter~~.—It is the intent of this chapter that the privilege of owning and operating a motor vehicle be exercised ~~to recognize the existing privilege to own or operate a motor vehicle on the public streets and highways of this state when such vehicles are used~~ with due consideration for others and their property in order~~, and~~ to promote safety and provide financial security requirements for ~~such~~ owners or operators whose responsibility it is to recompense others for injury to person or property caused by the operation of a motor vehicle. Therefore, this

chapter requires ~~it is required herein~~ that the owner or operator of a motor vehicle establish and maintain the ability to ~~involved in a crash or convicted of certain traffic offenses meeting the operative provisions of s. 324.051(2) shall~~ respond in ~~for such~~ damages and show proof of financial ability to respond for damages arising out of the use of a motor vehicle ~~in future accidents~~ as a requisite to his or her ~~future~~ exercise of such privileges.

Section 3. Subsections (1) and (7) 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.—A ~~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 for traction engines, road rollers, farm tractors, power shovels, and well drillers, and a ~~every~~ vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including a ~~any~~ bicycle or moped. ~~However, the term "motor vehicle" shall not include any motor vehicle as defined in s. 627.732(3) when the owner of such vehicle has complied with the requirements of ss. 627.730-627.7405, inclusive, unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.~~

(7) PROOF OF FINANCIAL RESPONSIBILITY.—~~That~~ Proof of

ability to respond in damages for liability on account of crashes arising out of the use of a motor vehicle:

(a) In the amount of $25,000 for ~~$10,000 because of~~ bodily injury to, or the death of, one person in any one crash;

(b) Subject to the ~~such~~ limits for one person under paragraph (a), in the amount of $50,000 for ~~$20,000 because of~~ bodily injury to, or the death of, two or more persons in any one crash;

(c) In the amount of $10,000 for damage ~~because of injury~~ to, or destruction of, the property of others in any one crash; and

(d) With respect to commercial motor vehicles and nonpublic sector buses, in the amounts specified in ss. 627.7415 and 627.742, respectively.

Section 4. Section 324.022, Florida Statutes, is amended to read:

324.022 Financial responsibility requirements ~~for property damage~~.—

(1)(a) The ~~Every~~ owner or operator of a motor vehicle required to be registered in this state shall establish and maintain the ability to respond in damages for liability on account of accidents arising out of the use of the motor vehicle in the amount of:

1. Ten thousand dollars for ~~$10,000 because of~~ damage to, or destruction of, property of others in any one crash.

2. Twenty-five thousand dollar for bodily injury to, or the death of, one person in any one crash and, subject to such limits for one person, in the amount of $50,000 for bodily injury to, or the death of, two or more persons in any one

crash.

(b) The requirements of this section may be met by one of the methods established in s. 324.031; by self-insuring as authorized by s. 768.28(16); or by maintaining an insurance policy providing coverage in at least the amounts for bodily injury liability coverage and property damage coverage specified in paragraph (a) ~~for property damage liability in the amount of at least $10,000 because of damage to, or destruction of, property of others in any one accident arising out of the use of the motor vehicle~~. The requirements of this section may also be met by having a policy that ~~which~~ provides coverage in the amount of at least $60,000 ~~$30,000~~ for combined property damage liability and bodily injury liability for any one crash arising out of the use of the motor vehicle.

(c) The policy, with respect to coverage for property damage liability and bodily injury liability, must meet the applicable requirements of s. 324.151, subject to the usual policy exclusions that have been approved in policy forms by the Office of Insurance Regulation.

(d) An ~~No~~ insurer does not ~~shall~~ have a ~~any~~ duty to defend uncovered claims regardless ~~irrespective~~ of their joinder with covered claims.

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

(a) "Motor vehicle" means a ~~any~~ self-propelled vehicle that has four or more wheels and ~~that~~ is of a type 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 does not include:

1. A mobile home.

2. A motor vehicle that is used in mass transit and designed to transport more than five passengers, exclusive of the operator of the motor vehicle, and that is owned by a municipality, transit authority, or political subdivision of the state.

3. A school bus as defined in s. 1006.25.

4. A vehicle providing for-hire transportation that is subject to ~~the provisions of~~ s. 324.031. The owner of a taxicab shall maintain security as required under s. 324.032(1).

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

(3) Each nonresident owner or registrant of a motor vehicle that, whether operated or not, has been physically present within this state for more than 90 days during the preceding 365 days shall maintain security as required by subsection (1) which ~~that~~ is in effect continuously throughout the period the motor vehicle remains within this state.

(4) An ~~The~~ owner or registrant of a motor vehicle who is ~~exempt from the requirements of this section if she or he is~~ a member of the United States Armed Forces and is called to or on active duty outside the United States in an emergency situation is exempt from this section. The exemption ~~provided by this subsection~~ applies only as long as the member of the armed forces is on ~~such~~ active duty outside the United States and applies only while the vehicle covered by the security is not operated by any person. Upon receipt of a written request by the insured to whom the exemption ~~provided in this subsection~~

applies, the insurer shall cancel the coverages and return any unearned premium or suspend the security required by this section. Notwithstanding s. 324.0221(2) ~~324.0221(3)~~, the department may not suspend the registration or operator's license of an ~~any~~ owner or registrant of a motor vehicle during the time she or he qualifies for the ~~an~~ exemption ~~under this subsection~~. An ~~Any~~ owner or registrant of a motor vehicle who qualifies for the ~~an~~ exemption ~~under this subsection~~ shall immediately notify the department before ~~prior to~~ and at the end of the expiration of the exemption.

Section 5. Subsections (1) and (2) of section 324.0221, Florida Statutes, are amended to read:

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

(1)(a) Each insurer that has issued a policy providing bodily injury liability ~~personal injury protection~~ coverage or property damage liability coverage shall report the renewal, cancellation, or nonrenewal thereof to the department within 45 days after the effective date of each renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing bodily injury liability ~~personal injury protection 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 10 ~~30~~ days. The report must ~~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 related 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 that provides ~~providing~~ bodily injury liability ~~personal injury protection 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 bodily injury liability ~~personal injury protection coverage~~ and property damage liability coverage on a motor vehicle 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 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 ss. 324.022 and 627.733 upon:

(a) The department's records showing that the owner or

registrant of such motor vehicle did not have the ~~in full force and effect when~~ required security in full force and effect ~~that complies with the requirements of ss. 324.022 and 627.733~~; or

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

Section 6. Section 324.023, Florida Statutes, is amended to read:

324.023 Financial responsibility for bodily injury or death.—In addition to any other financial responsibility required by law, every owner or operator of a motor vehicle that is required to be registered in this state, or that is located within this state, and who, regardless of adjudication of guilt, has been found guilty of or entered a plea of guilty or nolo contendere to a charge of driving under the influence under s. 316.193 after October 1, 2007, shall, by one of the methods established in s. 324.031(1) or~~,~~ (2), ~~or (3),~~ establish and maintain the ability to respond in damages for liability on account of accidents arising out of the use of a motor vehicle in the amount of $100,000 because of bodily injury to, or death of, one person in any one crash and, subject to such limits for one person, in the amount of $300,000 because of bodily injury to, or death of, two or more persons in any one crash and in the amount of $50,000 because of property damage in any one crash. If the owner or operator chooses to establish and maintain such ability by ~~posting a bond or~~ furnishing a certificate of deposit pursuant to s. 324.031(2) ~~or (3)~~, such ~~bond or~~ certificate of deposit must be in an amount not less than $350,000. Such higher limits must be carried for a minimum period of 3 years. If the

owner or operator has not been convicted of driving under the influence or a felony traffic offense for ~~a period of~~ 3 years from the date of reinstatement of driving privileges for a violation of s. 316.193, the owner or operator is ~~shall be~~ exempt from this section.

Section 7. Section 324.031, Florida Statutes, is amended to read:

324.031 Manner of proving financial responsibility.—The owner or operator of a taxicab, limousine, jitney, or any other for-hire passenger transportation vehicle may prove financial responsibility by providing satisfactory evidence of holding a motor vehicle liability policy as defined in s. 324.021(8) or s. 324.151, which ~~policy~~ is issued by an insurance carrier that ~~which~~ is a member of the Florida Insurance Guaranty Association. The operator or owner of any other vehicle may prove his or her financial responsibility by:

(1) Furnishing satisfactory evidence of holding such ~~a~~ motor vehicle liability policy ~~as defined in ss. 324.021(8) and 324.151~~;

~~(2) Posting with the department a satisfactory bond of a surety company authorized to do business in this state, conditioned for payment of the amount specified in s. 324.021(7),~~

(2)~~(3)~~ Furnishing a certificate of self insurance ~~the department~~ showing a deposit of cash or securities in accordance with s. 324.161; or

(3)~~(4)~~ Furnishing a certificate of self-insurance issued by the department in accordance with s. 324.171.

Any person, including a ~~any~~ firm, partnership, association, corporation, or other person, other than a natural person, electing to use the method of proof specified in subsection (2) or subsection (3) shall post a bond or deposit equal to the number of vehicles owned times $60,000 ~~$30,000~~, up to a maximum of $240,000. ~~$120,000.~~ In addition, any such person, other than a natural person, shall maintain insurance providing coverage in excess of limits of $25,000/50,000/10,000 ~~$10,000/20,000/10,000~~ or $60,000 ~~$30,000~~ combined single limits, and such excess insurance must ~~shall~~ provide minimum limits of $125,000/250,000/50,000 or $300,000 combined single limits. These increased limits do ~~shall~~ not affect the requirements for proving financial responsibility under s. 324.032(1).

Section 8. Section 324.071, Florida Statutes, is amended to read:

324.071 Reinstatement; renewal of license; reinstatement fee.—An ~~Any~~ operator or owner whose license or registration has been suspended pursuant to s. 324.051(2), s. 324.072, s. 324.081, or s. 324.121 may effect its reinstatement upon compliance with ~~the provisions of~~ s. 324.051(2)(a)3. or 4., or s. 324.081(2) and (3), as the case may be, and with one of the provisions of s. 324.031 and upon payment to the department of a nonrefundable reinstatement fee as specified in s. 324.0221 ~~of $15~~. Only one such fee shall be paid by any one person regardless ~~irrespective~~ of the number of licenses and registrations to be ~~then~~ reinstated or issued to such person. All such fees shall be deposited to a department trust fund. If ~~When~~ the reinstatement of any license or registration is effected by compliance with s. 324.051(2)(a)3. or 4., the

department may ~~shall~~ not renew the license or registration within ~~a period of~~ 3 years after ~~from~~ such reinstatement, nor may ~~shall~~ any other license or registration be issued in the name of such person, unless the operator continues ~~is continuing~~ to comply with one of the provisions of s. 324.031.

Section 9. Section 324.161, Florida Statutes, is amended to read:

324.161 Proof of financial responsibility; surety bond or deposit.—A ~~The~~ certificate of ~~the department of a~~ deposit issued by the department may be obtained by depositing $60,000 in ~~with it $30,000~~ cash or in securities that ~~such as~~ may be legally purchased by savings banks or for trust funds which have~~, of~~ a market value of $60,000 ~~$30,000~~ and which ~~deposit~~ shall be held by the department to satisfy, in accordance with ~~the provisions of~~ this chapter, any execution on a judgment issued against such person making the deposit~~,~~ for damages for ~~because of~~ bodily injury to or death of any person or for damages or ~~because of~~ injury to, or destruction of, property resulting from the use or operation of any motor vehicle occurring after such deposit was made. Money or securities so deposited are ~~shall~~ not ~~be~~ subject to attachment or execution unless such attachment or execution arises ~~shall arise~~ out of a suit for such damages ~~as aforesaid~~.

Section 10. Subsections (1) and (2) of section 324.171, Florida Statutes, are amended to read:

324.171 Self-insurer.—

(1) A ~~Any~~ person may qualify as a self-insurer by obtaining a certificate of self-insurance from the department. ~~which may, in its discretion and~~ Upon application of such a person, the department may issue a ~~said~~ certificate if the applicant ~~of~~

~~self-insurance when such person~~ has satisfied the requirements of this section ~~to qualify as a self-insurer under this section~~:

(a) A private individual with private passenger vehicles must ~~shall~~ possess a net unencumbered worth of at least $60,000 ~~$40,000~~.

(b) A person, including any firm, partnership, association, corporation, or other person, other than a natural person, must ~~shall~~:

1. Possess a net unencumbered worth of at least $60,000 ~~$40,000~~ for the first motor vehicle and $30,000 ~~$20,000~~ for each additional motor vehicle; or

2. Maintain sufficient net worth, as determined annually by the department~~,~~ pursuant to rules adopted ~~promulgated~~ by the department, with the assistance of the Office of Insurance Regulation of the Financial Services Commission, to be financially responsible for potential losses. The rules must consider any ~~shall take into consideration~~ excess insurance carried by the applicant. The department's determination shall be based upon reasonable actuarial principles considering the frequency, severity, and loss development of claims incurred by casualty insurers writing coverage on the type of motor vehicles for which a certificate of self-insurance is desired.

(c) The owner of a commercial motor vehicle, as defined in s. 207.002(2) or s. 320.01, may qualify as a self-insurer subject to the standards provided ~~for~~ in subparagraph (b)2.

(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 coverage under s. 627.733(3)(b)~~.

Section 11. Section 627.730, Florida Statutes, is repealed.

Section 12. Section 627.731, Florida Statutes, is repealed.

Section 13. Section 627.7311, Florida Statutes, is repealed.

Section 14. Section 627.732, Florida Statutes, is reordered and amended to read:

627.732 Definitions.—As used in ss. 627.733-627.7355 ~~627.730-627.7405~~, the term:

~~(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; nor does the term include a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent-owned by one or more hospitals or~~

~~physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:~~

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

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

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

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

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

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

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

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

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

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

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

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

(3)~~(5)~~ "Owner" means a person who holds the legal title to a motor vehicle; or, in the event a motor vehicle is the subject of a security agreement or lease with an option to purchase with

the debtor or lessee having the right to possession, then the debtor or lessee shall be deemed the owner ~~for the purposes of ss. 627.730-627.7405~~.

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

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

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

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

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

~~(11) "Lawful" or "lawfully" means in substantial compliance~~

~~with all relevant applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.~~

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

~~(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 agreed by the parties.~~

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

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

~~(16) "Emergency medical condition" means 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:~~

~~(a) Serious jeopardy to patient health.~~

~~(b) Serious impairment to bodily functions.~~

~~(c) Serious dysfunction of any bodily organ or part.~~

~~(17) "Entity wholly owned" means a proprietorship, group practice, partnership, or corporation that provides health care services rendered by licensed health care practitioners and in which licensed health care practitioners are the business owners of all aspects of the business entity, including, but not limited to, being reflected as the business owners on the title or lease of the physical facility, filing taxes as the business owners, being account holders on the entity's bank account, being listed as the principals on all incorporation documents required by this state, and having ultimate authority over all personnel and compensation decisions relating to the entity. However, this definition does not apply to an entity that is wholly owned, directly or indirectly, by a hospital licensed under chapter 395.~~

Section 15. Section 627.733, Florida Statutes, is amended to read:

627.733 Required security.—

(1)(a) The ~~Every~~ owner or registrant of a motor vehicle, other than a motor vehicle used as a school bus as defined in s. 1006.25 or limousine, required to be registered and licensed in this state shall maintain security as required by this section ~~subsection (3)~~ in effect continuously throughout the registration or licensing period.

(b) Notwithstanding paragraph (a), an ~~Every~~ owner or registrant of a motor vehicle used as a taxicab shall ~~not be~~

~~governed by paragraph (1)(a) but shall~~ maintain security as required under s. 324.032(1)~~, and s. 627.737 shall not apply to any motor vehicle used as a taxicab~~.

(2) Every nonresident owner or registrant of a motor vehicle that ~~which~~, whether operated or not, has been physically present within this state for more than 90 days during the preceding 365 days shall ~~thereafter~~ maintain security as required by this section ~~defined by subsection (3)~~ in effect ~~continuously~~ throughout the period the ~~such~~ motor vehicle remains within this state.

(3) Such security must ~~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 security required under s. 324.022 ~~the benefits and exemptions contained in ss. 627.730-627.7405~~. Any policy of insurance that provides, or is represented or sold as providing, the security required in this section is ~~hereunder 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) or~~,~~ (3)~~, or (4)~~ and approved by the Department of Highway Safety and Motor Vehicles as providing ~~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 shall have all of the obligations and rights of an insurer under ss. 627.730-627.7405.~~

~~(4) An owner of a motor vehicle with respect to which security is required by this section who fails to have such security in effect at the time of an accident shall have no~~

~~immunity from tort liability, but shall be personally liable for the payment of benefits under s. 627.736. With respect to such benefits, such an owner shall have all of the rights and obligations of an insurer under ss. 627.730-627.7405.~~

(4)~~(5)~~ ~~In addition to other persons who are not required to provide required security as required under this section and s. 324.022,~~ The owner or registrant of a motor vehicle who is ~~exempt from such requirements if she or he is~~ a member of the United States Armed Forces and is called to or on active duty outside the United States in an emergency situation is exempt from this section. The exemption ~~provided by this subsection~~ applies only as long as the member of the armed forces is on ~~such~~ active duty outside the United States and applies only while the vehicle covered by the security required by this section and s. 324.022 is not operated by any person. Upon receipt of a written request by the insured to whom the exemption ~~provided in this subsection~~ 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 an ~~any~~ owner or registrant of a motor vehicle during the time she or he qualifies for the ~~an~~ exemption ~~under this subsection~~. An ~~Any~~ owner or registrant of a motor vehicle who qualifies for the ~~an~~ exemption ~~under this subsection~~ shall immediately notify the department before ~~prior to~~ and at the end of the expiration of the exemption.

Section 16. Section 627.734, Florida Statutes, is amended to read:

627.734 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 ~~shall~~ apply to filing and maintaining proof of security required under s. 627.733 ~~by ss. 627.730-627.7405~~.

(2) Any person who:

(a) Gives information required in a report ~~or otherwise as provided for in ss. 627.730-627.7405,~~ knowing or having reason to 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 ~~is guilty of~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 17. Section 627.7401, Florida Statutes, is renumbered as section 627.7341, Florida Statutes, and amended to read:

627.7341 ~~627.7401~~ Notification of security requirements ~~insured's rights~~.—

(1) The commission, by rule, shall adopt a form for notifying ~~the notification of~~ insureds of the security required under s. 627.733 and the proof of security requirement under s. 627.734 ~~their right to receive personal injury protection benefits under the Florida Motor Vehicle No-Fault Law~~. Such

notice must ~~shall~~ include:

(a) A description of the benefits provided by bodily injury liability coverage and property damage liability coverage ~~personal injury protection, 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 personal injury protection benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, 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. 627.736(5)(c)1., if the insured notifies the insurer of a billing error, the insured may be entitled to a certain percentage of a reduction in the amount paid by the insured's motor vehicle insurer.~~

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

(2) Each insurer issuing a policy in this state providing the security required under s. 627.733 shall ~~personal injury protection benefits must~~ mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving notice from the insured ~~notice~~ of an automobile accident or claim involving ~~personal injury to~~ an insured who is covered under the policy. The office may allow an insurer up to 30 days of additional time to provide the notice ~~specified in subsection (1) not to exceed 30 days,~~ 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 security requirements of this part ~~act~~.

Section 18. Section 627.7355, Florida Statutes, is created to read:

627.7355 Motor vehicle insurance claims brought in a single action.—In any action in which the owner, registrant, operator, or occupant of a motor vehicle, to which security has been provided pursuant to s. 627.733, is claiming personal injury, 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 627.736, Florida Statutes, is repealed.

Section 20. Section 627.737, Florida Statutes, is repealed.

Section 21. Section 627.739, Florida Statutes, is repealed.

Section 22. Section 627.7403, Florida Statutes, is repealed.

Section 23. Section 627.7405, Florida Statutes, is repealed.

Section 24. Section 627.7407, Florida Statutes, is repealed.

Section 25. Sections 15 and 16 of chapter 2012-197, Laws of Florida, are repealed.

Section 26. 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). A ~~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, 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 to maintain personal injury protection insurance;~~ or that the vehicle is owned by another person.

Section 27. 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 bodily injury liability and property damage liability coverage ~~personal injury protection~~ benefits have been purchased if ~~when~~ required under ss. 324.022 and ~~s.~~ 627.733~~, that property damage liability coverage has been 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 may not ~~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 constitutes ~~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 ...(P~~ersonal Injury Protection,~~ Property Damage Liability~~,~~ and~~, when required,~~ Bodily Injury Liability)... Insurance currently in effect with ...(Name of insurance company)... under ...(policy number)... covering ...(make, year, 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 under ~~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 shall also indicate the existence of any bodily injury liability insurance voluntarily purchased.~~

(d) The verifying of proof of ~~personal injury protection insurance, 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 under the provisions of this chapter is ~~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 a ~~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, 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 after ~~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 28. 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 or~~ liability insurance.

Section 29. 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 application shall be in such form as may be prescribed by the department and is ~~shall be~~ subject to such rules ~~with respect thereto~~ as may be ~~so~~ prescribed by the department ~~it~~. The ~~Such~~ application shall be verified by oath or affirmation and must ~~shall~~ contain a full statement of the name and birth date of the person or persons applying for the license ~~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 the prior business in which the applicant has been engaged and its ~~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 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 shall 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 that will ~~which shall~~ be conducted at that location. The application must ~~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 must ~~shall~~ be included, or an independent (nonfranchised) motor vehicle dealer. The application must ~~shall~~ contain 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, $60,000 ~~$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 cannot be legally operated on roads, highways, or streets in this state. 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 applicant ~~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 30. 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 includes ~~shall include~~, at a minimum, $60,000 ~~$25,000~~ combined single-limit liability coverage, including bodily injury and property damage protection, ~~and $10,000 personal injury protection,~~ 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 investigation to be made to ascertain if the facts set forth in the application are true and shall not issue a license to the applicant until it is satisfied that the facts set forth in the application are true.

Section 31. Subsection (2) of section 322.251, Florida Statutes, is amended to read:

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

(2) The giving of notice and an order of cancellation, suspension, revocation, or disqualification by mail is complete ~~upon expiration of~~ 20 days after deposit in the United States mail for all notices except those issued under chapter 324 or ss. 627.733-627.734 ~~627.732-627.734~~, which are complete 15 days after deposit in the United States mail. Proof of the giving of notice and an order of cancellation, suspension, revocation, or disqualification in either manner shall be made by entry in the records of the department that such notice was given. The entry is admissible in the courts of this state and constitutes sufficient proof that such notice was given.

Section 32. Subsection (4) of section 400.9905, Florida Statutes, is amended, present subsection (7) of that section is renumbered as subsection (8), and new subsection (7) is added to that section, to read:

400.9905 Definitions.—

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

(a) Entities licensed or registered by the state under chapter 395; entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses under ss. 383.30-383.335, 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; 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; entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, 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; 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; entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, 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; 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; entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses under ss. 383.30-383.335, 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; 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 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 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 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 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.

(m) Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners where one or more of the owners is a health care practitioner who is licensed in

this state and who is responsible for supervising the business activities of the entity and is legally responsible for the entity's compliance with state law for purposes of this part.

(n) Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 where the billing for medical services is under a single tax identification number. The application for exemption under this subsection must include ~~shall contain information that includes~~: the name, residence~~,~~ and business address, and telephone ~~phone~~ number of the entity that owns the practice; a complete list of the names and contact information of all the officers and directors of the corporation; the name, residence address, business address, and medical license number of each licensed Florida health care practitioner employed by the entity; the corporate tax identification number of the entity seeking an exemption; a list ~~listing~~ of health care services to be provided by the entity at the health care clinics owned or operated by the entity and a certified statement prepared by an independent certified public accountant which states that the entity and the health care clinics owned or operated by the entity have not received payment for health care services related to a motor vehicle accident injury ~~under personal injury protection insurance coverage~~ for the preceding year. If the agency determines that an entity that ~~which~~ is exempt under this subsection has received payments for medical services related to a motor vehicle accident injury ~~under personal injury protection insurance coverage~~, the agency may deny or revoke the exemption from licensure under this subsection.

~~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).~~

(7) "Motor vehicle accident injury" means accidental bodily injury sustained while occupying a motor vehicle as defined in s. 627.732 or, if the injured party is not an occupant of a motor vehicle, an injury caused by physical contract with a motor vehicle.

Section 33. Subsection (6) of section 400.991, Florida Statutes, is amended 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 related to a motor vehicle accident injury ~~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 34. 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:

(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 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 relating to a motor vehicle accident injury ~~which was billed to all personal injury protection 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 35. 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 party, an insurer, or the agency, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for bodily ~~personal~~ injury or for death of the recipient, but specifically excluding ~~policies of~~ life insurance policies 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 coverage~~, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 36. 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~~, if ~~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~~,~~ ~~personal injury protection,~~ and casualty.

Section 37. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

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

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

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

Section 38. Paragraphs (gg) through (nn) of subsection (1) of section 456.072, Florida Statutes, are redesignated as paragraphs (ee) through (ll), respectively, and paragraphs (ee) and (ff) of that subsection 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 claim as required by s. 627.736, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732.~~

~~(ff) With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a~~

~~claim, statement, or bill for payment of services that were not rendered.~~

Section 39. Paragraph (i) 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 and unfair or deceptive acts or practices:

(i) *Unfair claim settlement practices.*—

1. Attempting to settle claims on the basis of an application~~,~~ when serving as a binder or intended to become a part of the policy, or any other material document that ~~which~~ was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds that are payable under a ~~such~~ contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, the ~~such~~ contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon

communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured, within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

~~i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority.~~

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential

property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant which ~~that~~ constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

Section 40. Paragraph (a) of 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 relating to a motor vehicle accident ~~under the Florida Motor Vehicle No-Fault Law~~.

b. A claim for payment or other benefit relating to a motor vehicle accident ~~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.

Section 41. Paragraph (a) of subsection (4) of section 626.9895, Florida Statutes, is amended to read:

626.9895 Motor vehicle insurance fraud direct-support organization.—

(4) BOARD OF DIRECTORS.—

(a) The board of directors of the organization consists ~~shall consist~~ of the following 11 members:

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

2. Two state attorneys, one ~~of whom shall be~~ appointed by the Chief Financial Officer and the other ~~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 the other ~~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 related to motor vehicle accidents ~~under ss. 627.730-627.7405~~, one ~~of whom shall be~~ appointed by the President of the Senate and the other ~~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 motor vehicle tort claims, ~~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 motor vehicle tort claims, ~~actions for benefits under ss. 627.730-627.7405, who shall be~~ appointed by the Speaker of the House of Representatives.

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~~, 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~~, 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 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~~, 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 ~~personal injury protection coverage and~~ medical payments coverage, if offered, of a motor vehicle insurance policy filed with the office must ~~shall~~ provide a premium discount if the insured vehicle is equipped with one or more air bags 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~~, personal injury protection,~~ or other coverage, the policy must ~~shall~~ provide that the insured or named insured is protected 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 onto ~~upon~~ that coverage. This section does not apply:

(1) To uninsured motorist coverage, 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 bodily ~~personal~~ injury liability ~~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's insurance to be primary; exception.—

(1) ~~The~~ Valid and collectible liability 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 required under s. 324.021(7) ~~and personal injury protection coverage as required by ss. 324.021(7) and 627.736~~.

(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~~ of an ~~any~~ authorized rental or leasing driver is primary for the limits of liability ~~and personal injury protection~~ coverage required under s. ~~by ss.~~ 324.021(7) ~~and~~

~~627.736~~, Florida Statutes."

Section 48. Subsections (8) through (10) of section 627.727, Florida Statutes, are renumbered as subsections (7) through (9), respectively, and subsection (1) and present subsection (7) of that section are amended, to read:

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

(1) No motor vehicle liability insurance policy which provides bodily injury liability coverage 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 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, must ~~shall~~ provide ~~for~~ a means to allow the insured to request such coverage, and must ~~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 is ~~shall be~~ over and above, but may ~~shall~~ not duplicate, the benefits available to an insured under any workers' compensation law, ~~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 does ~~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).~~

Section 49. Subsection (1) and paragraph (a) of subsection (2) of section 627.7275, Florida Statutes, are 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 may not be~~ delivered or issued for delivery in this state for a ~~with respect to any~~ specifically insured or identified motor vehicle registered or principally garaged in this state must provide ~~unless the policy also provides~~ coverage for property damage liability and bodily injury liability as required under ~~by~~ s. 324.022.

(2)(a) Insurers writing motor vehicle insurance in this state shall make available, subject to the insurers' usual underwriting restrictions:

1. Coverage under policies as described in subsection (1) to any applicant for private passenger motor vehicle insurance coverage who is seeking the coverage in order to reinstate the applicant's driving privileges in this state if ~~when the~~ driving privileges were revoked or suspended pursuant to s. 316.646 or s. 324.0221 due to the failure of the applicant to maintain required security.

2. Coverage under policies as described in subsection (1), which also provides bodily injury liability coverage and property damage liability coverage ~~for bodily injury, death, and property damage arising out of the ownership, maintenance, or use of the motor vehicle~~ in an amount not less than the limits described in s. 324.021(7) and conforms to the requirements of s. 324.151, to any applicant for private passenger motor vehicle insurance coverage who is seeking the coverage in order to

reinstate the applicant's driving privileges in this state after such privileges were revoked or suspended under s. 316.193 or s. 322.26(2) for driving under the influence.

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, ~~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 who are residents ~~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.

Section 51. Paragraphs (a) and (b) of subsection (1), paragraph (a) of subsection (5), and subsection (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 bodily injury liability ~~personal injury protection~~ coverage, property damage liability coverage, or both.

(b) "Binder" means a binder that provides motor vehicle bodily injury liability ~~personal injury protection~~ 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 agent's administrative costs ~~of the agent~~ associated with selling the motor vehicle insurance policy if the policy covers only bodily injury liability ~~personal injury protection~~ coverage ~~as provided by s. 627.736~~ 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.

(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 amount equal to~~ 2 months' premium from the insured. An insurer, agent, or premium finance company may not, directly or indirectly, take any action that results ~~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; or ~~. 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 if:

1. 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, bodily injury liability and ~~personal injury protection pursuant to ss. 627.730-627.7405;~~ motor vehicle property damage liability pursuant to s. 627.7275; or ~~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 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 if~~

2. 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. 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, the term ~~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 chapter 320.

(2) An accidental death and dismemberment policy sold in combination with a bodily injury liability ~~personal injury~~

~~protection~~ and property-damage-only ~~property damage only~~ policy.

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

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 bodily injury liability coverage ~~personal injury protection~~ and shall prescribe the form of such disclosure.

Section 53. 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; ~~personal injury protection benefits;~~ medical payments; comprehensive and collision. The information must ~~given 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 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 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 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 54. Present paragraph (e) of subsection (2) of section 628.909, Florida Statutes, is redesignated as paragraph (d), present paragraph (d) of that subsection is amended, present paragraph (e) of subsection (3) of that section is redesignated as paragraph (d), and present paragraph (d) of that subsection is amended, to read:

628.909 Applicability of other laws.—

(2) The following provisions of the Florida Insurance Code 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, when no-fault coverage is provided.~~

(3) The following provisions of the Florida Insurance Code

apply to industrial insured captive insurers to the extent that such provisions are not inconsistent with this part:

~~(d) Sections 627.730-627.7405 when no-fault coverage is provided.~~

Section 55. Subsections (2), (6), and (7) of section 705.184, Florida Statutes, are amended to read:

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,~~ 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,~~ and all persons of record claiming a lien against the motor vehicle. The notice 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 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 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 no storage fee 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,~~ 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 states ~~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,~~ and 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.

(b) The claim of lien shall be signed and sworn to or affirmed by the airport director or the director's designee.

(c) The claim of lien is ~~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, Florida Statutes~~, 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.

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,~~ 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.

(e) The claim of lien shall be recorded with the clerk of court in the county where the airport is located. The recording of the claim of lien shall be constructive notice to all persons of the contents and effect of such claim. The lien shall attach at the time of recordation and shall take priority as of that time.

Section 56. Subsection (4) of section 713.78, Florida Statutes, is 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, shall give notice to the registered owner, the insurance company insuring the vehicle ~~notwithstanding the provisions of s. 627.736~~, 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.

(b) If a ~~Whenever any~~ law enforcement agency authorizes the removal of a vehicle or vessel or if a ~~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~~.

(c) Notice by certified mail 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~~, and all persons of record claiming a lien against the vehicle or vessel. The notice 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 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.

(d) If attempts to locate the name and address of the owner or lienholder prove unsuccessful, the towing-storage operator shall, after 7 working days, excluding Saturday and Sunday, of the initial tow or storage, notify the public agency of jurisdiction where the vehicle or vessel is stored in writing by certified mail or acknowledged hand delivery that the towing-storage company has been unable to locate the name and address of the owner or lienholder and a physical search of the vehicle

or vessel has disclosed no ownership information and a good faith effort has been made. As used in ~~For purposes of~~ this paragraph and subsection (9), the term "good faith effort" means that the following checks have been performed by the company to establish prior state of registration and ~~for~~ title:

1. Check of vehicle or vessel for any type of tag, tag record, temporary tag, or regular tag.

2. Check of law enforcement report for tag number or other information identifying the vehicle or vessel~~,~~ if the vehicle or vessel was towed at the request of a law enforcement officer.

3. Check of trip sheet or tow ticket of tow truck operator to see if a tag was on vehicle or vessel at beginning of tow, if private tow.

4. If there is no address of the owner on the impound report, check of law enforcement report to see if an out-of-state address is indicated from driver license information.

5. Check of vehicle or vessel for inspection sticker or other stickers and decals that may indicate a state of possible registration.

6. Check of the interior of the vehicle or vessel for any papers that may be in the glove box, trunk, or other areas for a state of registration.

7. Check of vehicle for vehicle identification number.

8. Check of vessel for vessel registration number.

9. Check of vessel hull for a hull identification number, which should be carved, burned, stamped, embossed, or otherwise permanently affixed to the outboard side of the transom or, if there is no transom, to the outmost seaboard side at the end of the hull that bears the rudder or other steering mechanism.

Section 57. Paragraph (a) of subsection (1), paragraph (c) of subsection (7), paragraphs (a) through (c) of subsection (8), and subsections (9) and (10) 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 an ~~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;

3.a. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to an ~~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. 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 motor vehicle ~~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.

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report ~~prepared under s. 627.736(8)~~ 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 benefits required by s. 627.736~~. 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 benefits required by s. 627.736,~~ 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. 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 benefits required by s. 627.736~~. 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 benefits as required by s. 627.736~~. 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 motor vehicle ~~personal injury protection~~ insurance policy loses his or her license to practice for 5 years and may not receive reimbursement for bodily ~~personal~~ injury liability ~~protection~~ benefits for 10 years.

Section 58. Applicability; notice to policyholders.—

(1) As used in this section, the term "minimum security requirements" means security that enables a person to respond in damages for liability on account of accidents arising out of the use of a motor vehicle in the amount of $10,000 for damage to, or destruction of, property of others in any one crash; in the amount of $25,000 for bodily injury to, or the death of, one person in any one crash; and, subject to such limits for one person, in the amount of $50,000 for bodily injury to, or the death of, two or more persons in any one crash.

(2) Effective January 1, 2014:

(a) Motor vehicle insurance policies issued or renewed on or after that date may not include personal injury protection.

(b) Any person subject to ss. 324.022 and 627.733, Florida Statutes, must maintain at least minimum security requirements.

(c) Any new or renewal motor vehicle insurance policy delivered or issued for delivery in this state must provide

coverage that complies with minimum security requirements.

(d) An existing motor vehicle insurance policy issued before that date which provides personal injury protection and property damage liability coverage that meet the requirements of ss. 324.022 and 627.733, Florida Statutes, on December 31, 2013, but that do not meet minimum security requirements on or after January 1, 2014, shall be deemed to meet the security requirements of s. 324.022 and s. 627.733, Florida Statutes, until such policy is renewed, nonrenewed, or canceled on or after January 1, 2014.

(3) Each insurer shall allow each insured who has a new or renewal policy providing personal injury protection which becomes effective before January 1, 2014, and whose policy does not meet minimum security requirements on or after January 1, 2014, to change coverages so as to eliminate personal injury protection and obtain coverage providing minimum security requirements, which shall be effective on or after January 1, 2014. The insurer is not required to provide coverage complying with minimum security requirements in such policies if the insured does not pay the required premium, if any, by January 1, 2014, or such later date as the insurer may allow. Any reduction in the premium must be refunded by the insurer. The insurer may not impose an additional fee or charge on the insured which applies solely to a change in coverage; however, the insurer may charge an additional required premium that is actuarially indicated.

(4) By September 1, 2013, each motor vehicle insurer shall provide notice of the provisions of this section to each motor vehicle policyholder who is subject to this section. The notice

is subject to approval by the Office of Insurance Regulation and must clearly inform the policyholder that:

(a) The Florida Motor Vehicle No-Fault Law is repealed, effective January 1, 2014, and that on or after that date, the insured is no longer required to maintain personal injury protection insurance coverage, that personal injury protection coverage is no longer available for purchase in this state, and that all new or renewal policies issued on or after that date do not contain such coverage.

(b) Effective January 1, 2014, any person subject to the financial responsibility requirements of s. 324.022, Florida Statutes, must maintain minimum security requirements that enable such person to respond in damages for liability on account of accidents arising out of the use of a motor vehicle in the amount of $10,000 for damage to, or destruction of, property of others in any one crash; in the amount of $25,000 for bodily injury to, or the death of, one person in any one crash; and, subject to such limits for one person, in the amount of $50,000 for bodily injury to, or the death of, two or more persons in any one crash.

(c) Personal injury protection insurance pays covered medical expenses for injuries sustained in the motor vehicle crash by the policyholder, passengers, and relatives residing in the policyholder’s household.

(d) Bodily injury liability coverage protects the insured, up to the coverage limits, against loss if the insured is legally responsible for the death of or bodily injury to others in a motor vehicle accident.

(e) The policyholder may be able to obtain medical payments

coverage that pays covered medical expenses for injuries sustained in a motor vehicle crash by the policyholder and relatives residing in the policyholder's household, but that such coverage is not required under state law.

(f) Policyholders whose insurance policies do not contain bodily injury liability coverage are without coverage that protects against loss if the policyholder is legally responsible for the death or bodily injury of others in a motor vehicle accident.

(g) Underinsured motorist coverage provides benefits up to the limits of such coverage to a policyholder or other insured under the policy who is entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness, disease, or death in a motor vehicle accident.

(h) If the policyholder's new or renewal motor vehicle insurance policy is effective before January 1, 2014, and contains personal injury protection and property damage liability coverage as required by state law before January 1, 2014, but does not meet minimum security requirements on or after January 1, 2014, such policy shall be deemed to meet minimum security requirements until it is renewed, nonrenewed, or canceled on or after January 1, 2014.

(i) A policyholder whose new or renewal policy becomes effective before January 1, 2014, but does not meet minimum security requirements on or after January 1, 2014, may change coverages under the policy so as to eliminate personal injury protection and to obtain coverage providing minimum security requirements, including bodily injury liability coverage, which

are effective on or after January 1, 2014.

(j) If the policyholder has any questions, he or she should contact the name and phone number provided in the notice.

(5) This section shall take effect upon this act becoming a law.

Section 59. Application of suspensions for failure to maintain security; reinstatement.—All suspensions for failure to maintain required security as required by law in effect before January 1, 2014, remain in full force and effect after the effective date of this act. A driver may reinstate a suspended driver license or registration as provided under s. 324.0221.

Section 60. Except as otherwise expressly provided in this act, and except for this section, which shall take effect upon becoming law, this act shall take effect January 1, 2014.

Presentation on Personal Injury Protection (PIP) Insurance

Senate Banking & Insurance Committee

April 2, 2013

Sandra Starnes
Director, Property & Casualty Product Review

Part I:

Implementation of HB 119 From 2012

OIR Implementation Activities

- Informational Memoranda
- Updates to Office Forms
- Form Filings
- Actuarial Report

Actuarial Report

Contractor: Pinnacle Actuarial Resources, Inc.

Estimated savings:

- PIP losses: 16.3% - 28.7%
- PIP premiums (statewide): 14.0% - 24.6%
- Personal auto premiums: 2.8% - 4.9%

An important caveat in the report:
"The savings shown assume that current rates are adequate. To the extent that current PIP rates are inadequate, it is likely that insurers will offset the savings from HB 119 against the otherwise indicated PIP rates."

Note: PIP premiums represent approximately 20% of total personal auto premiums.

Change in PIP Premium From Rate Filings

Personal Auto Rate Filings Prior to HB 119:

- For filings effective on or after 1/1/2011 – More than 85% had approved increases in PIP. The majority were double-digit increases.

Results of 135 approved filings reflecting HB 119:

- 52% resulted in decreases
- 72% resulted in decreases or no changes

Change in PIP Premium From Rate Filings (cont.)

Filing summary for the Top 25 Personal Auto Insurers (represents 80% of the market):

Amount of PIP Change	Number of Filings	Market Share
Decrease of at least 10%	10	42%
Decrease less than 10%	4	5%
No change	4	8%
Increase	7	25%

The weighted average approved PIP change of the Top 25 insurers was -2.0%.

If State Farm's filing is removed, the weighted average change was -4.8%.

Filings for Top 5*
Personal Auto Insurers

Company Name	Market Share*	File Number	Company Indication Before HB 119	Selected PIP Percentage Change
State Farm Mutual Auto Insurance	17.5%	12-15711	+22.0%	7.9%
GEICO General Insurance	10.3%	12-15922	+16.8%	-10.0%
Progressive American Insurance	6.3%	12-15814	-0.8%	-10.0%
Progressive Select Insurance	5.3%	12-15813	-0.4%	-10.0%
GEICO Indemnity	4.8%	12-15922	+15.7%	-10.0%

* Based on 2012 Total Personal Auto premiums reported on FL state page of the annual statement.

Part II:

Replacing PIP with Mandatory Bodily Injury (BI) Coverage

Estimated Premium Impacts

Description of Coverages

- Personal Injury Protection (PIP)
- Bodily Injury (BI)
- Property Damage (PD)
- Medical Payments (Med-Pay or MP)
- Uninsured Motorist (UM)
- Comprehensive (COMP)
- Collision (COLL)

Methodology

- 2 rating examples used

- 5 large auto insurers were reviewed
  - 3 represent the non-standard market
  - 2 represent the standard or preferred market

- To reflect the elimination of PIP:

  - 50% of the PIP premium was moved to BI
  - 20% of the PIP premium was moved to MP, and
  - 10% of the PIP premium was moved to UM

Summary of Premium Impacts

From: Minimum Required Limits ($10,000 PIP/$10,000 PD)
To: PIP Eliminated and:

10/20/10 (BI/PD) Limits

- Non-standard insurers experienced decreases across all regions
- Standard/preferred insurers decreases in regions where PIP fraud was prevalent

25/50/10 (BI/PD) Limits

- Central Miami only region with decrease for all insurers

If **Full Coverage policies purchased** (BI, PD, PIP, UM, MP, COMP & COLL), all insurers experienced decreases in premium if BI, PD, and UM limits remain constant.

Limits shown as A/B/C where the BI limit per person is $A, BI limit per occurrence is $B, and PD limit is $C.

Estimated Impact by Region - Central Miami Married Couple – Both Age 40

	Policies with Minimum Required Limits			Policies with Full Coverage (10/20/10/1)		
	PIP/PD	BI/PD* 10/20/10	Change	No-Fault	Tort * System	Change
Non-Standard Company A	$2,824.12	$1,760.81	**-38%**	$3,926.84	$3,405.48	**-13%**
Non-Standard Company B	$1,897.75	$1,461.38	**-23%**	$4,201.25	$3,871.50	**-8%**
Non-Standard Company C	$1,710.00	$1,456.00	**-15%**	$3,872.00	$3,601.20	**-7%**
Stand./Pref. Company D	$707.32	$587.01	**-17%**	$1,640.10	$1,527.29	**-7%**
Stand./Pref. Company E	$1,335.45	$1,049.79	**-21%**	$2,401.36	$2,162.30	**-10%**

Source: Premium shown is annual premium from Rate Collection System information for recent personal auto rate filing. Limits shown as A/B/C/D where the BI limit per person is $A, BI limit per occurrence is $B, PD limit is $C and MP limit (if applicable) is $D.
* Includes adjustment to reflect elimination of PIP.

Estimated Impact by Region - Tallahassee Married Couple – Both Age 40

	Policies with Minimum Required Limits			Policies with Full Coverage (10/20/10/1)		
	PIP/PD	BI/PD* 10/20/10	Change	No-Fault	Tort * System	Change
Non-Standard Company A	$414.88	$409.50	**-1%**	$1,046.00	$989.87	**-5%**
Non-Standard Company B	$646.00	$652.00	**1%**	$2,027.00	$1,944.20	**-4%**
Non-Standard Company C	$565.00	$628.00	**11%**	$1,705.00	$1,648.60	**-3%**
Stand./Pref. Company D	$235.30	$253.93	**8%**	$862.15	$833.02	**-3%**
Stand./Pref. Company E	$245.80	$345.88	**41%**	$894.22	$861.42	**-4%**

Source: Premium shown is annual premium from Rate Collection System information for recent personal auto rate filing. Limits shown as A/B/C/D where the BI limit per person is $A, BI limit per occurrence is $B, PD limit is $C and MP limit (if applicable) is $D.
* Includes adjustment to reflect elimination of PIP.

Part III:

PIP
&
the Patient Protection and Affordable Care Act (PPACA)

Interplay Between PIP and PPACA

PIP provides additional benefits beyond the medical services and care, such as lost wages and death benefits (estimated to be approximately 9% of PIP payments).

In addition, even under PPACA:

- Some will refuse to purchase health insurance.
- Some will purchase high deductible plans.
- For those over age 65, Medicare Part A only covers hospital costs. Part B (Medical Services) and Part D (Prescription Drugs) are still optional.

Contact:

Sandra Starnes
Director, Property & Casualty Product Review
Phone: (850) 413-5314
Email: Sandra.Starnes@floir.com

THE FLORIDA SENATE

APPEARANCE RECORD

4-9-13
Meeting Date

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

Topic No-Fault Repeal

Bill Number SPB 7152 *(if applicable)*

Name BONNY GORDON

Amendment Barcode _____ *(if applicable)*

Job Title SENIOR COUNSEL

Address 1 GEICO Plaza *Street*

Phone (O) 301-986-2653

Washington, DC 20076
City *State* *Zip*

E-mail bgordon@geico.com

Speaking: ☐ For ☐ Against ☐ Information ☒ Not currently supporting

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 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)

2-9-13
Meeting Date

Topic Mandatory BI

Bill Number S 7152 *(if applicable)*

Name ALEX R. SPASSOFF

Amendment Barcode *(if applicable)*

Job Title (L.M.T.) Licensed Massage Therapist

Address 307 N. Howard Ave
Street

Phone 813-843-4904

TAMPA FL 33606
City *State* *Zip*

E-mail alex@suncoastmassage.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

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SPB 7150
INTRODUCER:	For consideration by the Banking and Insurance Committee
SUBJECT:	Public Records/Insurance Policies
DATE:	April 6, 2013
REVISED:	

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

I. Summary:

SPB 7150 applies the public records exemption for motor vehicle insurance policy numbers and personal identifying information of insureds to policies providing bodily injury liability insurance, rather than policies providing personal injury protection. The exemptions of the bill are subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.

The bill takes effect on the same date that an unspecified legislative act (SPB 7152) or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

This bill substantially amends the following sections of the Florida Statutes: 324.242

II. Present Situation:

Public Records Law

The State of Florida has a long history of providing public access to governmental records. The Florida Legislature enacted the first public records law in 1892.[1] One hundred years later, Floridians adopted an amendment to the State Constitution that raised the statutory right of

[1] Section 1390, 1391 F.S. (Rev. 1892).

access to public records to a constitutional level.[2] Article I, s. 24 of the State Constitution, provides that:

> Every person has the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

In addition to the State Constitution, the Public Records Act,[3] which pre-dates public records provision of the State Constitution, specifies conditions under which public access must be provided to records of an agency.[4] Section 119.07(1)(a), F.S., states:

> (a) Every person who has custody of a public record shall permit the record to be inspected and examined by any person desiring to do so, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.

Unless specifically exempted, all agency records are available for public inspection. The term "public record" is broadly defined to mean:

> . . . all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.[5]

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are used to perpetuate, communicate, or formalize knowledge.[6] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[7]

Only the Legislature is authorized to create exemptions to open government requirements.[8] Exemptions must be created by general law and such law must specifically state the public

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[2] Article I, s. 24, Fla. Constitution.
[3] Chapter 119, F.S.
[4] The word "agency" is defined in s. 119.011(2), F.S., to mean ". . . 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." The Florida Constitution also establishes a right of access to any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except those records exempted by law or the state constitution.
[5] Section 119.011(11), F.S.
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Associates, Inc.*, 379 So.2d 633, 640 (Fla. 1980).
[7] *Wait v. Florida Power & Light Company*, 372 So.2d 420 (Fla. 1979).
[8] Article I, s. 24(c), Fla. Constitution.

necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law.[9] A bill enacting an exemption[10] may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[11]

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency or to anyone other than to the persons or entities designated in the statute.[12] If a record is simply made exempt from disclosure requirements, then an agency is not prohibited from disclosing the record in all circumstances.[13]

Open Government Sunset Review Act

The Open Government Sunset Review Act (Act)[14] provides for the systematic review, through a 5-year cycle ending October 2 of the 5th year following enactment, of an exemption from the Public Records Act or the Public Meetings Law. Each year, by June 1, the Division of Statutory Revision of the Office of Legislative Services is required to certify to the President of the Senate and the Speaker of the House of Representatives the language and statutory citation of each exemption scheduled for repeal the following year.[15]

The Act states that an exemption may be created or expanded only if it serves an identifiable public purpose and if the exemption is no broader than necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. An exemption meets the three statutory criteria if it:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, whose administration would be significantly impaired without the exemption;
- Protects information of a sensitive, personal nature concerning individuals, the release of which would be defamatory or cause unwarranted damage to the good name or reputation of such individuals, or would jeopardize their safety; or
- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information that is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[16]

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[9] *Memorial Hospital-West Volusia v. News-Journal Corporation*, 729 So. 2d 373, 380 (Fla. 1999); *Halifax Hospital Medical Center v. News-Journal Corporation*, 724 So.2d 567 (Fla. 1999).
[10] Under s. 119.15, F.S., an existing exemption may be considered a new exemption if the exemption is expanded to cover additional records.
[11] Art. I, s. 24(c), Fla. Constitution.
[12] Attorney General Opinion 85-62.
[13] *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).
[14] Section 119.15, F.S.
[15] Section 119.15(5)(a), F.S.
[16] Section 119.15(4)(b), F.S.

The Act also requires consideration of the following:

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

Section 324.242, F.S., Exemption

Every Florida registrant of a motor vehicle must obtain and provide proof of holding a motor vehicle insurance policy that includes $10,000 in personal injury protection (PIP).[17] Additionally, s. 324.022, F.S., requires owners and operators of Florida-registered motor vehicles to maintain the ability to pay at least $10,000 in property damage, which may be met by maintaining $10,000 in property damage liability coverage.[18] A higher financial requirement is placed on commercial motor vehicles, taxicab owners and operators, for-hire passenger transportation vehicles, and registered vehicle owners or operators found guilty or that have plead nolo contendere to driving under the influence.[19]

The Department of Highway Safety and Motor Vehicles (DHSMV) is notified by insurers that supply policies with personal injury protection or property damage liability coverage of renewals, cancellations, and non-renewals of these policies within 45 days of their effective dates, as required by s. 324.0221, F.S. The insurer must also notify the named insured in writing of the cancellation or non-renewal of a policy and give notice of the consequences from the failure of maintaining PIP and property damage coverage, including the loss of registration, loss of driving privileges, and imposition of reinstatement fees. The records held by the DHSMV contain the insurance company code, the policy number, driver's license number, personal identifying information (name and address), and information identifying the vehicle, including the vehicle identification number and the make, model, and year of the vehicle.

Section 324.242, F.S., exempts from public records requirements personal identifying information, including the name, address, and driver's license number of insureds and former insureds and the insurance policy number contained in PIP and property damage liability motor vehicle insurance policies.[20] The exemption serves to protect sensitive personal information concerning individuals whose reputation or safety from identity theft would be jeopardized if the information were released. The exemption also protects confidential information used for business advantage against competitors. The disclosure of this information could injure insurance

[17] Section 627.733, F.S.
[18] Section 324.022, F.S.
[19] See ss. 324.023, F.S., and 324.032, F.S.
[20] The statutory predecessor to s. 324.242, F.S, was s. 627.736(9)(a), F.S., which was repealed as part of the Florida Motor Vehicle No-Fault Law on October 1, 2007.

companies in the market since competitors would be able to solicit the business of their policyholders. The information exempted by s. 324.242, F.S., is neither obtainable by alternate means nor protected under other exemptions. However under s. 324.242, F.S., the DHSMV must release the policy number for a vehicle involved in an accident to any person involved in the accident, the attorney of any person involved in the accident, or a representative of the insurer of any person involved in the accident upon receipt of a written request and copy of the crash report.

III. Effect of Proposed Changes:

Section 1 amends s. 324.242, F.S., to apply the public records exemption for motor vehicle insurance policy numbers and personal identifying information of insureds to policies providing bodily injury liability insurance, rather than policies providing personal injury protection. The exemptions of the bill are subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 states that the Legislature finds that it is a public necessity to make certain information regarding bodily injury liability insurance policies held by the DHSMV confidential and exempt from the requirements of s. 119.07(1), F.S., and s. 24(a), Article I of the State Constitution. The Legislature finds that automobile drivers must be properly insured for BI liability and PD liability in order to ensure public safety on the state's roads and highways. As such, insurers must report to the DHSMV and verify the issuance of a new insurance policy to a driver, as well as the renewal, nonrenewal, or cancellation of that policy. Such information includes the personal identifying information of an insured or former insured and the insurance policy number of the insured, which, if compiled, could result in a customer list of every insurer in the state. This information is traditionally considered proprietary business information because such lists could be used by competitors to solicit customers. Consequently, the release of that information could injure the insurer in the marketplace. Further, public access to such information could be used to perpetuate fraud against an insured and put him or her at risk or to make the insured the target of uninvited solicitations from other insurers or from others seeking to profit from motor vehicle accidents.

Section 3 provides that the effective date of the bill is the same date that an unspecified legislative act (SPB 7152) or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Please see *Section II. Present Situation* of this Staff Analysis.

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:

On line 18, "personal injury protection" should be reinstated because SB 7150 will not repeal the Florida Motor Vehicle No-Fault Law prior to the effective date of this bill. Line 71 of the bill should be amended to refer to SB 7152.

VII. Related Issues:

The proposed bill will only take effect upon the enactment of SPB 7152, or similar legislation, that repeals the Florida Motor Vehicle No-Fault Law and requires owners and operators of motor vehicle registered in this state to obtain bodily injury liability coverage.

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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-03132-13 20137150__

A bill to be entitled

An act relating to public records; amending s. 324.242, F.S.; providing a public records exemption for certain information regarding bodily injury liability insurance policies and deleting the exemption for personal injury protection policies; providing for future legislative review and repeal of the exemption for information regarding certain liability insurance policies 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. Section 324.242, Florida Statutes, is amended to read:

(1) The following information regarding bodily injury liability ~~personal injury protection~~ and property damage liability insurance policies held by the department is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Personal identifying information of an insured or former insured; and

(b) An insurance policy number.

(2) Upon receipt of a written request and a copy of a crash report as required under s. 316.065, s. 316.066, or s. 316.068, the department shall release the policy number for a policy covering a vehicle involved in a motor vehicle accident to:

(a) Any person involved in such accident;

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(b) The attorney of any person involved in such accident; or

(c) A representative of the insurer of any person involved in such accident.

(3) This exemption applies to personal identifying information of an insured or former insured and insurance policy numbers held by the department before, on, or after October 11, 2007.

(4) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds and declares that it is a public necessity to make certain information regarding bodily injury liability insurance policies held by the Department of Highway Safety and Motor Vehicles confidential and exempt from the requirements of s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. In order to ensure public safety on the roads and highways of this state, it is imperative that automobile drivers be properly insured for liability for bodily injury, as well as damage to real property. As such, insurers are required to report to the Department of Highway Safety and Motor Vehicles and verify the issuance of a new policy to a driver, as well as the renewal, nonrenewal, or cancellation of that policy. Such information includes the personal identifying information of an insured or former insured as well as the insurance policy number of the insured. If this information is compiled, it could result in a customer list of every insurer in the state. Customer lists contain detailed

client and policy information that is traditionally considered proprietary business information because such lists could be used by competitors to solicit customers. Consequently, the release of that information could injure the insurer in the marketplace by diminishing the advantage that the insurer maintains over those who do not possess such information. Further, public access to such information could be used to perpetuate fraud against an insured and put him or her at risk or to make the insured the target of uninvited solicitations from other insurers or from others seeking to profit from motor vehicle accidents.

Section 3. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

CourtSmart Tag Report

Room: EL 110 **Case:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 4/9/2013 1:34:30 PM
Ends: 4/9/2013 3:29:52 PM Length: 01:55:23

1:34:36 PM Meeting called to order by Chairman.
1:36:10 PM CAA calls roll -- quorum
1:36:30 PM Senator Simmons turn chair over to VC Clemens
1:36:48 PM TAB 5 -- SB 860 - Sen. Galvano recognized to explain bill
1:38:27 PM Sen. Montford for CS -- adopted
1:39:27 PM Roll call on CS/SB 860 -- favorable
1:40:32 PM TAB 3 - SB 814 by Sen. Brandes
1:40:48 PM Delete all amend. -- w/o adopted
1:41:28 PM Senator Montford for CS -- adopted
1:41:36 PM roll call on bill -- passed
1:42:44 PM TAB 14 -- CS/SB 360
1:43:44 PM Roll call on CS/SB 360 -- favorable
1:44:45 PM SB 1128 - Health Flex Plans
1:45:27 PM Delete all amendment by Sen. Hays (704482) --w/o adopted
1:46:15 PM Roll call on CS/SB 1128 -- favorable
1:47:16 PM CS/SB 844 - Medicaid Fraud
1:48:17 PM Roll call on CS/SB 844 -- Favorable
1:48:54 PM SB 144 by Sen. Altman
1:49:30 PM Explanation of bill by Aide
1:49:48 PM Amd.141354 by Sen. Benacquisto --w/o adopted
1:50:31 PM Roll call on CS/S B 144 -- Favorable
1:51:36 PM SB 1302 by Senator Garcia
1:52:04 PM Roll call on SB 1302 -- Favorable
1:53:08 PM SB 1098 by Sen. Richter
1:53:25 PM Explanation of bill by Sen. Richter
1:53:36 PM Amd. 264374 -technical amd. -- w/o adopted
1:53:55 PM Amd. 836278 - technical amendment -- w/o adopted
1:54:16 PM Motion for CS -- w/o adopted
1:54:51 PM Roll call on SB 1098 -- Favorable
1:55:44 PM SB 418 by Sen. Detert
1:56:00 PM Explanation of bill by Sen. Detert
1:56:55 PM Roll call on SB 418 -- Favorable
1:57:40 PM CS/SB 536 by Senator Detert
1:58:37 PM Amd. 340402 -- tp'd
1:59:30 PM SB 1408 by Senator Richter
2:00:14 PM Explanation of bill by Sen. Richter
2:00:36 PM AMD. 214592 -- w/o adopted
2:00:52 PM Roll call on CS/S B 1408 -- favorable
2:01:46 PM S 1006 by Senator Lee -- Explanation of bill by Sen. Lee
2:03:33 PM Roll call on SB 1006 -- Favorable
2:04:14 PM CS/SB 536 by Sen. Detert --Explanation of bill by Sen. Detert
2:05:30 PM Roll call on CS/SB 536 --Favorable
2:06:50 PM SB 1302 -- Motion for CS -- Diaz de la Portia
2:07:29 PM Roll call on CS/SB 1302 -- Favorable
2:10:12 PM Senator Clemens turns chair over to Senator Richter
2:18:52 PM Sen. Richter turns chair back to Chairman Simmons
2:23:21 PM Presentation by Ms. Starnes
2:23:49 PM Bonny Gordon, Senior Councel, GEICO
2:26:28 PM Alex Spassoff, Licensed Massage Therapist
2:32:13 PM Remarks by Chairman on PIP
2:33:24 PM Senate Confirmation Hearing for Barry Gilway - Executive Director, Citizens Property Ins. Corp.
2:39:17 PM Senator Richter recognized for comment.

2:52:40 PM Questions posed by Chairman to Barry Gilway
2:53:04 PM Question by Sen. Montford
2:56:55 PM Question by Sen. Montford
3:02:58 PM Questions by Senator Clemens
3:29:39 PM Meeting adjourned