Civil Justice Subcommittee

Wednesday, March 23, 2011
8:00 AM
404 HOB

REVISED

Dean Cannon
Speaker

Eric Eisnaugle
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Civil Justice Subcommittee

Start Date and Time: Wednesday, March 23, 2011 08:00 am

End Date and Time: Wednesday, March 23, 2011 11:00 am

Location: 404 HOB
Duration: 3.00 hrs

Consideration of the following bill(s):

HB 703 Liability of Spaceflight Entities by Goodson
CS/HB 967 Personal Injury Protection Insurance by Insurance & Banking Subcommittee, Horner
HB 1019 Foster Care Providers by Plakon
HB 1237 Legal and Medical Referral Service Advertising by Kriseman

NOTICE FINALIZED on 03/21/2011 15:50 by Jones.Missy

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 703 Liability of Spaceflight Entities
SPONSOR(S): Goodson
TIED BILLS: None **IDEN./SIM. BILLS:** SB 652

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Economic Development & Tourism Subcommittee	14 Y, 0 N	Tecler	Kruse
2) Civil Justice Subcommittee		Billmeier LMB	Bond MB
3) Economic Affairs Committee			

SUMMARY ANALYSIS

Current law provides liability protection to spaceflight entities in the event of an injury to or death of a participant engaging in spaceflight activities, provided certain warnings are given to and signed by the participant. This law is repealed effective October 2, 2018. This bill deletes the scheduled repeal.

The bill does not appear to have a fiscal impact on state or local government.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

In order to encourage growth in the commercial spaceflight industry, Congress enacted the Commercial Space Launch Amendments Act of 2004 ("the Act").[1] The Act establishes informed consent requirements for commercial human spaceflight and provides certain protections to licensed entities that engage in commercial human spaceflight.

The provisions of the Act include a "fly at your own risk" clause that allows a licensed entity to carry spaceflight participants only if the licensed entity informs participants in writing about the risks of the launch and reentry, including the safety record of the launch or reentry vehicle.[2] After being fully informed, participants must provide written consent.[3] The Act does not require spaceflight participants to waive liability for any non-governmental entity.

The Act also includes licensed entities in a temporary indemnification and insurance arrangement that requires the licensed entity to purchase insurance, but provides government indemnification up to $1.5 billion beyond the insurance cap.[4] This has the effect of shielding licensed entities from high insurance costs due to the risk of a catastrophic event.

In general, states offer liability protection for commercial human spaceflights as an incentive measure to attract or retain commercial spaceflight activity in their state. In addition to Florida, Virginia and New Mexico provide liability protection for entities engaging in commercial human spaceflight.[5] Last year, the Virginia General Assembly repealed the sunset date of the Virginia law.[6] The New Mexico law provides a sunset date of July 1, 2018.

Florida Liability Protection

Section 331.501, F.S. provides that a spaceflight entity[7] is not liable for injury to or death of a spaceflight participant resulting from the inherent risks of spaceflight activities,[8] provided the required warning is given to and signed by the participant. A participant or participant's representative may not recover damages from a spaceflight entity for the loss, damage, or death of the participant resulting exclusively from any of the inherent risks of spaceflight activities. The limitation on liability is in addition to any other limitation of legal liability that might otherwise be provided by law. Further, immunity provided under current law does not apply if the injury was proximately caused by the spaceflight entity and the spaceflight entity:[9]

- Commits gross negligence or willful or wanton disregard for the safety of the participant;
- Has actual knowledge or reasonably should have known of a dangerous condition; or
- Intentionally injures the participant.

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[1] 49 U.S.C. ss. 70101-70305.
[2] 49 U.S.C. s. 70105(b)(5).
[3] 49 U.S.C. s. 70105(b)(5)(C).
[4] 49 U.S.C. ss. 70112-13. $500 million in coverage for third party claims. $100 million for property damage claims by the United States.
[5] Va. Code ss. 8.01-227.8 through 8.01-227.10. NMSA 1978, ss. 41-14-1 through 41-14-4.
[6] HB 21 repealed the sunset date of July 1, 2013.
[7] Section 331.501(1)(c), F.S. defines "spaceflight entity" as a public or private entity holding a United States Federal Aviation Administration launch, reentry, operator, or launch site license for spaceflight activities.
[8] As defined in s. 331.501(1)(b), F.S., the term "spaceflight activities" means launch services or reentry services as those terms are defined in 49 U.S.C. s. 70102.
[9] Section 331.501(2)(b), F.S.

To receive the immunity provided under current law, the spaceflight entity must have each participant sign a required warning statement.[10] The warning must contain, at a minimum, the following statement:

> WARNING: Under Florida law, there is no liability for an injury to or death of a participant in a spaceflight activity provided by a spaceflight entity if such injury or death results from the inherent risks of the spaceflight activity. Injuries caused by inherent risks of spaceflight activities may include, among others, injury to land, equipment, persons, and animals, as well as the potential for you to act in a negligent manner that may contribute to your injury or death. You are assuming the risk of participating in this spaceflight activity.[11]

Unless reenacted by the Legislature, the provisions of this section are repealed on October 2, 2018.[12]

Effect of the Bill

The bill amends s. 331.501, F.S. to remove the repeal of October 2, 2018.

The bill provides an effective date of July 1, 2011.

B. SECTION DIRECTORY:

Section 1: Amends s. 331.501, F.S., removing the sunset date.

Section 2: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:
   None.

2. Expenditures:
   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:
   None.

2. Expenditures:
   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

By removing the repeal, the bill may have the effect of encouraging private sector economic activity.

D. FISCAL COMMENTS:

None.

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[10] Section 331.501(3)(a), F.S.
[11] Section 331.501(3)(b), F.S.
[12] Section 331.501(4), F.S.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to the liability of spaceflight entities; amending s. 331.501, F.S.; saving a provision from future repeal which provides spaceflight entities with immunity from liability for the loss, damage, or death of a participant resulting from the inherent risks of spaceflight activities; providing an effective date.

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

Section 1. Section 331.501, Florida Statutes, is amended to read:

331.501 Spaceflight; informed consent.—

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

(a) "Participant" means any spaceflight participant as that term is defined in 49 U.S.C. s. 70102.

(b) "Spaceflight activities" means launch services or reentry services as those terms are defined in 49 U.S.C. s. 70102.

(c) "Spaceflight entity" means any public or private entity holding a United States Federal Aviation Administration launch, reentry, operator, or launch site license for spaceflight activities.

(2)(a) Except as provided in paragraph (b), a spaceflight entity is not liable for injury to or death of a participant resulting from the inherent risks of spaceflight activities so long as the warning contained in subsection (3) is distributed and signed as required. Except as provided in paragraph (b), a

participant or participant's representative may not maintain an action against or recover from a spaceflight entity for the loss, damage, or death of the participant resulting exclusively from any of the inherent risks of spaceflight activities.

(b) Paragraph (a) does not prevent or limit the liability of a spaceflight entity if the spaceflight entity does any one or more of the following:

1. Commits an act or omission that constitutes gross negligence or willful or wanton disregard for the safety of the participant and that act or omission proximately causes injury, damage, or death to the participant;

2. Has actual knowledge or reasonably should have known of a dangerous condition on the land or in the facilities or equipment used in the spaceflight activities and the danger proximately causes injury, damage, or death to the participant; or

3. Intentionally injures the participant.

(c) Any limitation on legal liability afforded by this subsection to a spaceflight entity is in addition to any other limitation of legal liability otherwise provided by law.

(3)(a) Every spaceflight entity providing spaceflight activities to a participant, whether such activities occur on or off the site of a facility capable of launching a suborbital flight, shall have each participant sign the warning statement specified in paragraph (b).

(b) The warning statement described in paragraph (a) shall contain, at a minimum, the following statement:

"WARNING: Under Florida law, there is no liability for an injury to or death of a participant in a spaceflight activity provided by a spaceflight entity if such injury or death results from the inherent risks of the spaceflight activity. Injuries caused by the inherent risks of spaceflight activities may include, among others, injury to land, equipment, persons, and animals, as well as the potential for you to act in a negligent manner that may contribute to your injury or death. You are assuming the risk of participating in this spaceflight activity."

(c) Failure to comply with the warning statement requirements in this section shall prevent a spaceflight entity from invoking the privileges of immunity provided by this section.

~~(4) This section expires October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.~~

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 967 Personal Injury Protection Insurance
SPONSOR(S): Insurance & Banking Subcommittee, Horner and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1694

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	13 Y, 2 N, As CS	Reilly	Cooper
2) Civil Justice Subcommittee		Woodburn	Bond
3) Health & Human Services Committee			
4) Economic Affairs Committee			

SUMMARY ANALYSIS

The Florida Motor Vehicle No-Fault Law (No-Fault Law) requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. PIP provides payment of medical, surgical, funeral and disability benefits to the named insured and persons injured while in, or struck by, the insured motor vehicle without regard to fault. In return for assurance of payment of these benefits, the No-Fault Law places limitations on lawsuits for non-economic damages (pain and suffering). PIP is designed to compensate individuals quickly and efficiently and reduce automobile insurance costs and litigation.

Committee Substitute for House Bill 967 makes various changes to Florida's no-fault motor vehicle law, as follows:

- Authorizes PIP insurance policies that require or allow the use of arbitration to resolve disputes.
- Grants exclusive original jurisdiction to circuit courts to hear challenges to PIP arbitration decisions; provides for a trial de novo (new trial) in circuit court. Requires insurers to pay the costs of arbitration as well as attorney fees in certain situations.
- Caps attorney fee awards in disputes under the No-Fault Law at $10,000 ($50,000 in class actions) or three times the disputed amount recovered, whichever is less. Bars use of a contingency risk multiplier in determining fee awards in No-Fault cases.
- Permits insurers to use the schedule of maximum charges that is based on Medicare Part B when providing reimbursement for durable medical equipment and care and services rendered by clinical laboratories.
- Provides that reimbursement for care and services rendered in ambulatory surgical centers may be limited to 80 percent of the workers' compensation fee schedule.
- Establishes that when PIP reimbursement is made under a Medicare-based schedule of maximum charges, that the applicable Medicare schedule in effect on January 1st is to be used throughout the year in calculating reimbursement, regardless of any subsequent changes in Medicare rates.
- Requires insureds who are seeking PIP benefits to comply with all terms of the insurance policy, including submitting to an examination under oath (EUO). Makes compliance with policy terms a condition precedent to eligibility for policy benefits. Permits EUOs to be recorded.
- Requires assignees of PIP payment rights to comply with policy terms and cooperate with the insurer, including submitting to an EUO. Requires the insurer to make a written request for information sought before requesting an EUO from an assignee. Entitles assignees to reasonable compensation for time spent participating in an EUO.
- Provides that it is an unfair and deceptive trade practice for an insurer, as a general business practice, to request EUOs without a reasonable basis.

This bill does not appear to have a fiscal impact on state or local government.

The bill provides for a July 1, 2011 effective date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

No-Fault Motor Vehicle Insurance

Florida is one of 12 states[1] with no-fault motor vehicle[2] insurance provisions. The purpose of the Florida Motor Vehicle No-Fault Law (No-Fault Law)[3] is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida motorists are required to carry a minimum of $10,000 of personal injury protection coverage (PIP) and $10,000 of property damage liability coverage.[4,5] PIP is no-fault automobile insurance.

History of the PIP System

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan, which took effect January 1, 1972. Under a no-fault system, medical and other benefits are provided without regard to fault in return for limitations on lawsuits for non-economic damages. Since its enactment, various changes have been made to the No-Fault Law.

In 2000, a Statewide Grand Jury found rampant fraud in the PIP system. Reform legislation was enacted in 2001,[6] which adopted many of the Grand Jury's recommendations, including requiring certain health care clinics to register with the Department of Health and providing criteria for medical directors; applying fee schedules for certain procedures; limiting access to motor vehicle crash reports to curtail illegal solicitation; and providing that insurers/insureds are not required to pay claims of brokers.

Additional changes to the PIP system were enacted in 2003.[7] These included strengthening health care clinic regulation; requiring agency licensure with the Agency for Health Care Administration; requiring all PIP claimants to send a pre-suit demand letter to insurers for unpaid benefits; specifying criteria as to "reasonable" charges for services; strengthening various criminal penalties for PIP fraud; and providing for the repeal of the No-Fault Law on October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session.

In 2006, SB 2114, a bill that would have extended the repeal date of the No-Fault Law and made other changes, was passed by the Legislature and subsequently vetoed. The No-Fault Law then repealed on October 1, 2007.[8]

In Special Session C of 2007, the Legislature passed CS/HB 13C, which revived and reenacted the No-Fault Law effective January 1, 2008. The bill, signed into law as ch. 2007-324, L.O.F., limits medical reimbursement to services and care provided by specified health care providers and entities; authorizes insurers to use schedules of maximum charges in calculating reimbursement for medical services,

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[1] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance systems. See the Insurance Information Institute's update on "No-Fault Auto Insurance." Available at: http://www.iii.org/media/hottopics/insurance/nofault/ (last accessed: March 13, 2011).
[2] "Motor vehicle" is defined in s. 627.732, F.S., and includes private passenger motor vehicles and commercial motor vehicles.
[3] Sections 627.730-627.7405, F.S.
[4] Section 627.7275, F.S.
[5] Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for bodily injury and property damage liability at the time of motor vehicle accidents or when serious traffic violations occur.
[6] Chapter 2001-271, L.O.F.
[7] Chapter 2003-411, L.O.F.
[8] The Motor Vehicle No-Fault Law was repealed pursuant to s. 19, ch. 2003-411, F.S.

supplies, and care; and provides that an insurer's failure to pay PIP claims as a general business practice is an unfair and deceptive trade practice.

Current PIP Provisions

Under current law, PIP provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. PIP benefits are payable as follows:

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

PIP provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries. Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:[9]

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

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

Overdue PIP Benefits and Jurisdictional Issues

Pre-Suit Demand Letter

PIP insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue.[10] Before filing a lawsuit for overdue PIP benefits, the aggrieved person must given the insurer written notice of intent to sue.[11] If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

Florida Courts

Under the Florida judicial system, the trial jurisdiction of county courts is established by statute. Currently, civil disputes involving $15,000 or less are within county court jurisdiction.[12] As Florida does not have a separate system of "small claims courts," small claims are captured under the jurisdiction of county courts. The Florida Small Claims Rules apply to civil actions in county court in which the demand or value of the property involved is $5,000 or less. These rules are designed to foster a simple, efficient, and inexpensive remedy at law for litigants.[13] Many PIP disputes are heard under the small claims jurisdiction of county courts.

In contrast to county courts, circuit courts have general trial jurisdiction over matters not assigned by statute to the county courts and also hear appeals from county court cases. Thus, circuit courts are simultaneously the highest trial courts and the lowest appellate courts in Florida's judicial system. The

[9] Section 627.737, F.S.
[10] Section 627.736(4)(b), F.S.
[11] Section 627.736(10), F.S.
[12] http://www.floridasupremecourt.org/pub_info/system2.shtml (last accessed: March 13, 2011).
[13] "Review of the Small Claims Process in Florida." Interim Report 2009-121 by staff of the Florida Senate Committee on the Judiciary (October 2008).

trial jurisdiction of circuit courts includes original jurisdiction over civil disputes involving more than $15,000.[14]

Mandatory Arbitration with Limited Rights on Appeal under Former s. 627.736(5), F.S., Held Unconstitutional

In *Nationwide Mutual Fire Insurance Co. v. Pinnacle Medical, Inc.*,[15] the Florida Supreme Court held s. 627.736(5), F.S., which required medical providers to submit PIP claims to binding arbitration and provided limited rights on appeal, an unconstitutional denial of medical providers' access to courts under s. 21, Art. I of the Florida Constitution. As the right of assignees to sue for breach of contract predates the Florida Constitution, the right could not be abolished by the Legislature without providing a reasonable alternative, absent a showing of overpowering public necessity and no alternative for meeting this necessity. The Court held that the challenged arbitration process, with the scope of appeal limited to that available under the Florida Arbitration Code, chapter 682, F.S., did not constitute a reasonable alternative and that the Legislature had not shown an overpowering necessity to abolish this right. In contrast to the statute at issue, the Court noted its decision in *Chrysler Corporation v. Pitsirelos*,[16] in which it upheld a mandatory arbitration provision under the Motor Vehicle Warranty Act that entitled either party on appeal to a trial de novo on the grounds that it respected the parties' right of access to courts.

Attorney Fee Awards to "Prevailing" PIP Claimants

Lodestar Calculation

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court calculates the lodestar, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[17]

In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar:[18]

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

Contingency Risk Multiplier

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the lodestar in determining the fee award.[19] For example, if the lodestar were $20,000 and the court determined it appropriate to apply a contingency risk multiplier of 2.5, the fee award would be $50,000 ($20,000 lodestar x 2.5).

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[14] http://www.floridasupremecourt.org/pub_info/system2.shtml (last accessed: March 13, 2011).
[15] 753 So.2d 55 (Fla. 2000).
[16] 721 So.2d 710 (Fla. 1998).
[17] The federal lodestar approach to determining fee awards was adopted by the Florida Supreme Court in *Florida Patient's Compensation Fund v. Rowe*, 472 So.2d 1145 (Fla. 1985).
[18] *See* Rule 4-1.5(b) of the Rules Regulating the Florida Bar.
[19] *Standard Guaranty Insurance Co. v. Quanstrom*, 555 So.2d 828 (Fla. 1990).

The Florida Supreme Court, in *Florida Patient's Compensation Fund v. Rowe*,[20] authorized the use of contingency risk multipliers in personal injury cases on two grounds:

- It provides personal injury claimants with increased access to courts.
- Since attorneys working on a contingency fee basis are not paid if they do not prevail, they must charge more for their services than an attorney who is guaranteed payment.

Subsequently, in *Standard Guaranty Insurance Co. v. Quanstrom*,[21] the Court clarified that use of a contingency risk multiplier was not mandatory, but was within the trial court's discretion.

In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[22]

Currently there is a split of authority between the First and Fifth District Courts of Appeal with respect to the evidence required to support the use of a contingency risk multiplier in calculating a fee award under s. 627.428, F.S. In *Progressive Express Insurance Co. v. Schultz*,[23] the 5th DCA held that use of a contingency risk multiplier in a PIP action was improper because the policyholder did not testify that he had any difficulty obtaining legal representation, there was no evidence presented on the issue, and the lawsuit was essentially a straightforward contract case involving $1,315. In *Massie v. Progressive Express Insurance Co.*,[24] the issue before the 1st DCA was whether use of a contingency risk multiplier was proper when the PIP claimant did not testify that she had difficulty obtaining counsel, but expert testimony was offered that the claimant would have had such difficulty without the opportunity for a multiplier. On direct appeal, the 1st DCA, relying on *Schultz,* held that use of a multiplier was improper, and the claimant petitioned for certiorari review. Based on circuit precedent, the 1st DCA granted the petition, quashed the order on direct appeal, and affirmed the trial court's used of a contingency risk multiplier based on expert testimony.

Examinations of Insureds and Examinations Under Oath

In *Custer Medical Center v. United Automobile Insurance Co.*,[25] a passenger injured in an automobile accident failed to appear for two medical examinations requested by the insurer. At the time the requests were made, the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Florida Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer on the following grounds. Attendance at a medical examination is not a condition precedent to the existence of an automobile insurance policy. A dispute concerning attendance at a medical examination concerns an insured's right to receive "subsequent" PIP benefits pursuant to s. 627.736(7)(b), F.S., under an existing insurance policy, and is not a dispute about the policy's existence. Additionally, s. 627.737(7), F.S., provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits. Here, it was not shown that the injured passenger's failure to attend medical examinations constituted an "unreasonable refusal" to submit to examination. Further, the claim sought payment for medical services that had been provided before, and not after, the passenger failed to appear for examination.

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[20] 472 So.2d 1145 (Fla. 1985).
[21] 555 So.2d 828 (Fla. 1990).
[22] *See Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[23] 948 So.2d 1027 (Fla. 5th DCA 2007).
[24] 25 So.3d 584 (Fla. 1st DCA 2009).
[25] 2010 WL 4344089 (Fla.).

Assignment of PIP Benefits

In *Shaw v. State Farm Fire and Casualty Co.*,[26] the 5th DCA held that policy language that required any person making a claim or seeking payment to submit to an examination under oath (EUO) did not require a health care provider who had been assigned PIP payment rights for services rendered to submit to an EUO. The 5th DCA based its decision on the following:

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

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

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

Effect of the Bill:

Arbitration of PIP Disputes

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the use of arbitration to resolve PIP disputes. A demand for arbitration, which can be made by the insurer or a claimant, must be in writing and sent by certified mail. Arbitration must be held within 60 days of receipt of the arbitration request, and the 60-day period will not be tolled for the discovery of documents. Claimants are required to make available for inspection and copying all records upon which they intend to rely at the arbitration within 15 days of receipt of the insurer's written request for information. Insurers are required to make available for inspection and copying all records it intends to rely on at arbitration within 10 days of receipt of such request. Discovery from an insurer is limited to documents, records, and information concerning insurance coverage, and does not extend to require the production of privileged information, underwriting files, documents that will not be relied on at arbitration, or documents relating to claims handling processes.

The arbitration will be conducted by a single arbitrator, selected by the chief judge of the judicial district in which the arbitration is to be held, and will take place in the county in Florida in which treatment was rendered. If treatment was in another state, the arbitration will take place in the county in which the claimant resides, unless the parties agree on another location. Insurers are responsible for reasonable costs directly associated with arbitration.

The arbitrator's written decision must be provided to the parties within 30 days of the arbitration and is binding on the parties, unless challenged within 20 days of receipt by filing a complaint in circuit court. The arbitration award cannot exceed the remaining coverage limits on the PIP policy. Claimants who prevail in arbitration will be reimbursed by the insurer for reasonable costs and attorney fees directly associated with the arbitration. The attorney fee award is limited to $10,000 ($50,000 in class actions) or three times any disputed amount recovered, whichever is less. The award of fees and costs must be set forth in the arbitration award.

If the insurer pays the arbitration award, but the claimant files a challenge in circuit court, the claimant is not eligible for a fee award relating to the court proceedings,[27] and interest will not accrue on the amount in dispute during the course of the litigation. The circuit court will conduct a trial de novo (new trial) of the dispute.

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[26] 37 So.3d 329 (Fla. 5th DCA 2010).

[27] The bill provides that s. 627.428, F.S., (awarding of attorney fees as an insured or benificary who prevails against in an insurer) does not apply to a circuit court review of a decision by the arbitrator.

Attorney Fees

The use of contingency risk multipliers in calculating fee awards in disputes under the No-Fault Law is prohibited. As is the case in PIP arbitration proceedings, fee awards in no-fault litigation are capped at $10,000 ($50,000 in class actions) or three times the disputed amount recovered, whichever is less.

PIP Reimbursement under Schedules of Maximum Charges

PIP reimbursement for medical services, supplies, and care is under a schedule of maximum charges based upon the annual Medicare Part B[28] fee schedule developed by the Centers for Medicare and Medicaid Services (CMS). Currently, CMS develops annual fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.[29] The bill provides that the PIP schedule of maximum charges, which is reimbursement at 80 percent of 200 percent of Medicare Part B, may be used by insurers to provide reimbursement for durable medical equipment, and care and services rendered by clinical laboratories.

Reimbursement for care and services provided by ambulatory surgical centers may be limited to 80 percent of the workers' compensation fee schedule.

For PIP schedules of maximum reimbursement that are based on Medicare, the applicable Medicare schedule in effect on January 1st is to be used throughout the year when calculating reimbursement for care, services, and supplies rendered in that year, regardless of subsequent changes to Medicare rates. However, the reimbursement amount may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

Examinations Under Oath and Compliance with Terms of PIP Policies

The bill legislatively addresses the *Shaw* and *Custer* decisions. Compliance with policy terms by any insured seeking benefits under a PIP policy is made a condition precedent to eligibility for policy benefits. Compliance includes, when the policy so provides, submitting to an examination under oath (EUO) when requested by the insurer. An EUO may be recorded. An insured's failure to appear for examination (mental or physical) is presumed to be an unreasonable refusal to submit to examination. The presumption, however, is rebuttable, and may be overcome by the claimant upon showing that the failure to attend was not an unreasonable refusal to submit to examination.

Assignees of PIP payment rights are also required to comply with policy terms and to cooperate with the insurer, including submitting to an EUO upon insurer request. The insurer is required to make a written request for information before requesting an EUO from an assignee. When an insurer requests an EUO, the medical provider must produce those individuals with the most knowledge of the issues identified by the insurer. Assignees are entitled to reasonable compensation for time spent participating in an EUO.

An insurer that, as a general business practice, requests EUOs without a reasonable basis commits an unfair and deceptive trade practice.

Miscellaneous

The bill also provides as follows:

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[28] Medicare Part B covers doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.

[29] "Fee Schedules – General Information," The Centers for Medicare and Medicaid Services, http://www.cms.gov/FeeScheduleGenInfo/ (Last visited on March 14, 2011)

- Requests for insurance-related information made to self-insured corporations must be sent by certified mail to the registered agent of the disclosing entity.
- Insurers that deny reimbursement due to improperly completed medical statements or bills are required to notify the provider about the specific provisions that were not properly completed and to give the provider 15 days to submit a properly completed form.

B. SECTION DIRECTORY:

Section 1 amends s. 26.012, F.S., regarding circuit court jurisdiction to challenges to PIP arbitration awards.

Section 2 amends s. 627.4137, F.S., regarding requests for insurance-related information.

Section 3 creates s. 627.7311, F.S., regarding Legislative intent.

Section 4 amends s. 627.736, F.S., regarding personal injury protection (PIP) coverage.

Section 5 provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent this bill helps reduce litigation and contain costs now associated with uncapped attorney fees, the cost of PIP insurance should be reduced.

Some health care providers may find the new requirements placed on them by this bill, including arbitration, burdensome. Health care providers may opt not to accept assignment. Consequently, injured parties would have to pay for their treatment up front and seek reimbursement from their insurers.

D. FISCAL COMMENTS:

The costs to the public sector associated with the arbitration process delineated in the bill are unknown. Arbitration is currently used to settle disputes outside of the courts. Arbitration of PIP disputes may reduce the court docket, but possible reductions of costs to the court are indeterminate at this time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill provides that the chief judge of the circuit is to select an arbitrator in the instance that one of the parties elects arbitration. It is unclear what the procedure would be for the chief judge to select the arbitrator nor is it clear who would set the arbitrator's fees.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 16, 2011, the Insurance & Banking Subcommittee adopted a proposed committee substitute for HB 967. The PCS:

- Provides that the circuit court has jurisdiction for all actions involving the Florida Motor Vehicle No-Fault Law where an arbitration decision is challenged.
- Deletes legislative intent relating to no-fault insurance.
- Creates s. 627.7311, F.S., regarding effect of law on no-fault polices.
- Provides that an insured must comply with the terms of the policy including submitting to examinations under oath and that compliance is a condition precedent to benefits.
- Provides that arbitration must take place within 60 days of the receipt of notice of arbitration rather than providing that arbitration not occur sooner than 30 days after receipt of notice and must occur no later than 20 days after discovery.
- Limits discovery of certain documents.
- Provides that the chief judge of the circuit county choose one arbitrator rather than the parties each choosing an arbitrator and the two arbitrators choosing a third arbitrator.
- Deletes subsection providing for how a prevailing party is determined in arbitration.
- Provides that the insurer is to pay the costs of arbitration rather than the non-prevailing party or if there is not a prevailing party, the parties are to split the costs of arbitration.
- Provides that the court review of the arbitration decision is de novo rather than a review of the record.

- Provides that s. 627.428, F.S., does not apply in an appeal of a arbitration decision, rather than s. 627.428, F.S., not apply only if the insurer pays the arbitration decision and the opposing party appeals the decision.

A bill to be entitled

An act relating to personal injury protection insurance; amending s. 26.012, F.S.; providing that the circuit court has exclusive original jurisdiction in actions involving challenges to arbitration decisions under the Florida Motor Vehicle No-Fault Law; amending s. 627.4137, F.S.; requiring requests made to a self-insured corporation for disclosure of certain information to be by certified mail; creating s. 627.7311, F.S.; providing for the effect of specified statutory provisions, schedules, and procedures on insurance policies; amending s. 627.736, F.S.; requiring an insured seeking benefits to comply with policy terms as a condition precedent to receiving benefits; revising a reference to Medicare Part B payments as the schedule for an insurer's discretionary use when limiting reimbursement of certain medical services, supplies, and care; specifying the Medicare fee schedule or payment limitation that is to be used by an insurer to limit reimbursements for certain medical services, supplies, and care; requiring that an insurer under certain circumstances notify a provider of an improperly completed form and provide an opportunity to submit a completed form within a specified time; requiring any assignee of benefits or payments to cooperate under the terms of the policy; requiring a provider who is assigned the benefits of an insured to submit to examination under oath under certain circumstances; requiring a provider to produce certain knowledgeable individuals for examination

under oath under certain circumstances; requiring certain records be provided by claimants for inspection if requested by an insurer; authorizing methods for recording examinations under oath; providing that certain actions by an insurer constitute an unfair and deceptive trade practice; subjecting insurers to penalties for an unfair and deceptive trade practice; creating a presumption relating to failing to appear for an examination; specifying that submitting to an examination is a condition precedent to receiving benefits; providing for application relating to attorney's fees; limiting the amount of recoverable attorney's fees; prohibiting the use of a contingency risk multiplier when calculating attorney's fees; authorizing binding arbitration as a policy provision for dispute resolution; providing requirements and procedures relating to arbitration; providing for the recovery of specified attorney's fees and costs in arbitration; providing for a judicial challenge of an arbitration decision; providing for the scope of review relating to such challenge; providing that s. 627.428, F.S., relating to attorneys' fees, does not apply to a challenge of an arbitration decision; prohibiting the accrual of interest during litigation of such challenge under certain circumstances; providing an effective date.

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

Section 1. Subsection (2) of section 26.012, Florida Statutes, is amended to read:

26.012 Jurisdiction of circuit court.—

(2) The circuit court ~~They~~ shall have exclusive original jurisdiction:

(a) In all actions at law not cognizable by the county courts.~~;~~

(b) Of proceedings relating to the settlement of the estates of decedents and minors, the granting of letters testamentary, guardianship, involuntary hospitalization, the determination of incompetency, and other jurisdiction usually pertaining to courts of probate.~~;~~

(c) In all cases in equity including all cases relating to juveniles except traffic offenses as provided in chapters 316 and 985.~~;~~

(d) Of all felonies and of all misdemeanors arising out of the same circumstances as a felony which is also charged.~~;~~

(e) In all cases involving legality of any tax assessment or toll or denial of refund, except as provided in s. 72.011.~~;~~

(f) In actions of ejectment.~~; and~~

(g) In all actions involving the title and boundaries of real property.

(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, where arbitration is initiated pursuant to s. 627.736(18) and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

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

Section 3. Section 627.7311, Florida Statutes, is created to read:

627.7311 Effect of law on policies.—The provisions, schedules, and procedures authorized in ss. 627.730-627.7405 shall be implemented by the insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Law. These provisions, schedules, and procedures have full force and effect regardless of their express inclusion in an insurance policy, and an insurer is not required to amend its policy to implement and apply such provisions, schedules, or procedures.

Section 4. Paragraph (i) is added to subsection (4) of section 627.736, Florida Statutes, paragraphs (a) and (d) of subsection (5), paragraph (b) of subsection (6), paragraph (b) of subsection (7), and subsection (8) of that section are amended, and subsections (17) and (18) are added to that section, to read:

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

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are

covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(i) In all circumstances, an insured seeking benefits under ss. 627.730-627.7405 must comply with the terms of the policy, which includes, but is not limited to, submitting to examinations under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

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

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

1.~~2.~~ The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

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

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

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

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

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

outpatient services.

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

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

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

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

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

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology

(CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A ~~No~~ statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein. If an insurer denies a claim under this section due to the failure of a provider to provide a properly completed form required by this paragraph, the insurer shall notify the provider as to the provisions that were improperly completed and shall give the provider 15 days to submit a completed form.

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if~~; provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial. Such sworn statement must ~~shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs

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

1. If an insured seeking to recover benefits under ss. 627.730-627.7405 assigns the contractual right to those benefits or the payment of those benefits to any person or entity, the assignee shall comply with the terms of the policy. In all circumstances, the assignee shall be obligated to cooperate under the policy, which includes, but is not limited to, participation in an examination under oath. For time spent in an examination under oath, the assignee is entitled to reasonable compensation from the insurer. Compliance with this paragraph is a condition precedent to the recovery of benefits under ss. 627.730-627.7405. If an insurer requests an examination under oath of a medical provider, the provider must produce those individuals with the most knowledge of the issues identified by

the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer that are reasonably obtainable by the claimant. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof.

2. Prior to requesting that an assignee participate in an examination under oath, the insurer must provide a written request of the assignee for all information that the insurer believes is necessary to the processing of the claim, including the information contemplated in subparagraph 1. An assignee is not relieved from the provisions of this subparagraph simply by providing the information contemplated in subparagraph 1.

3. Any insurer that, as a general practice, requests examinations under oath without a reasonable basis is engaging in an unfair and deceptive trade practice.

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

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

examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for ~~subsequent~~ personal injury protection benefits incurred after the date of the requested examination. Failure to appear for an examination raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to receiving benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (10) and (15) and except that any attorney's fees recovered are limited to the lesser of $10,000 or three times any disputed amount recovered by the attorney under ss. 627.730-627.7405. Attorney's fees in a class action under ss. 627.730-627.7405 are limited to the lesser of $50,000 or three times the total of any disputed amount recovered in the class action proceeding.

(17) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the attorney's fees recovered under ss. 627.730-627.7405 shall be calculated without regard to any contingency risk multiplier.

(18) ARBITRATION.—In order to provide for an expedited,

cost-effective, and fair resolution of disputes arising from contracts for personal injury protection benefits, an insurer may offer a policy that requires or allows the insurer or claimant to demand arbitration of any claims dispute involving personal injury protection benefits prior to filing a lawsuit and in lieu of litigation. Arbitration is subject to the Florida Arbitration Code, except as otherwise provided in this section. In addition:

(a) A demand for arbitration must be made in writing by certified mail, and the arbitration must be held within 60 days after the receipt of a request for arbitration. The 60-day period may not be tolled for discovery of documents pursuant to paragraph (d).

(b) Arbitration shall take place in the county in which the treatment was rendered. If treatment was rendered outside the state, arbitration shall take place in the county in which the insured resides unless the parties agree to another location.

(c) The arbitration shall be conducted by a single arbitrator selected by the chief judge of the judicial circuit in which the arbitration is being held.

(d)1. The claimant shall make available for inspection or copying the medical and other records on which the claimant intends to rely at arbitration, upon written request by the insurer or his or her attorney, within 15 days after receipt of such request.

2. The insurer shall make available for inspection or copying all documents, records, or information upon which it is

relying in adjusting or rejecting the claim, upon written request by the claimant or his or her attorney, within 10 days after receipt of such request.

3. Discovery of insurer documents, records, or information shall be limited to those relating to insurance coverage. The insurer is not required to produce claims-privileged items, underwriting files, or documents that it does not intend to rely on at arbitration.

4. There shall be no discovery relating to general claims-handling practices.

(e) The decision of the arbitrator shall be set forth in writing and furnished to each party within 30 days after the arbitration. The decision shall be binding on each party unless challenged pursuant to paragraph (g). An arbitration award may not exceed the applicable limits of coverage remaining on the policy.

(f) The claimant is entitled to reimbursement of attorney's fees directly associated with the arbitration, subject to subsection (8). The award of fees must be set forth in the arbitration decision. The insurer shall bear all reasonable costs directly associated with the arbitration process.

(g)1. A party may challenge the arbitration decision by filing a complaint in circuit court within 20 days after the receipt of the arbitration decision.

2. Review of the arbitration shall be de novo.

3. Section 627.428 does not apply, and interest on the amount in dispute may not accrue during the course of

litigation, if the insurer has tendered payment of the amount of the arbitration award to the claimant.

Section 5. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1019 Foster Care Providers
SPONSOR(S): Plakon and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1500

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Access Subcommittee	11 Y, 4 N	Poche	Schoolfield
2) Civil Justice Subcommittee		Thomas	Bond
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 1019 reduces the general liability insurance requirement for an eligible lead community-based provider ("lead agency") and a subcontractor of a lead agency involved in the community-based care (CBC) program to provide foster care services to abused and neglected children in Florida. The bill also caps the economic and non-economic damages recoverable in a tort action by a claimant or claimant(s) against a lead agency or subcontractor, or against multiple entities involved in the same incident.

The bill provides that the Department of Children and Families (DCF) is not liable in tort for acts or omissions of a lead agency, or a subcontractor of the lead agency, or the officers, agents, or employees of the lead agency or subcontractor. The bill prohibits DCF from requiring a lead agency or a subcontractor to indemnify DCF against the department's own acts or omissions. Further, the bill provides that DCF may not require a lead agency or subcontractor to include the department as an additional insured on any insurance policy.

The bill does not appear to have fiscal impact on state or local government.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

DCF is one of the state agencies responsible for providing assistance and services to abused and neglected children. Prior to 1996, DCF accomplished its mission by directly delivering child protection services to recipients. In 1996, DCF began to privatize child protection services through a CBC pilot program.[1] Through the CBC program, private companies, known as "lead agencies", enter into a contract with DCF to provide foster care services, child abuse services, mental health services, and other types of assistance.

Upon evaluating the program, DCF found that the lead agencies were able to have more frequent in-person contact with children in the program, to achieve lower ratios of children per home, to maintain smaller caseloads per case worker, and to have a lower average number of per child placement changes.[2] Due to the success of the pilot program, the Legislature significantly amended s. 409.1671, F.S., to create the CBC program privatizing foster care services, which remains largely unchanged today.[3] There are currently 20 lead agencies providing these and other services across the state.[4] Lead agencies use subcontractors to deliver services directly to recipients.

Among many other facets of the CBC program, current law requires mandatory liability insurance limits to be maintained by lead agencies and their subcontractors.[5] In addition to the mandatory insurance limits, current law allows for a yearly increase of 5 percent in the conditional limitation on damages available to claimants to account for the annual increase in the cost of goods and services.[6] Lead agencies and subcontractors must maintain a minimum level of general liability insurance of $1 million per claimant and $3 million per liability incident.[7] Economic damages[8] per claimant are capped at $1,550,000.[9] Non-economic damages[10] per claimant are capped at $310,000.[11] In addition, lead agencies and subcontractors must maintain minimum bodily injury liability insurance coverage of $100,000 per claim and $300,000 per incident.[12] Also, providers must maintain $1,000,000 in non-owned automobile insurance coverage.[13] This coverage is secondary to the primary insurance coverage of $100,000 per claim and $300,000 per incident that must be maintained by employees of lead agencies or subcontractors who use their personal vehicles to transport children and families in the course of providing services.[14]

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[1] State of Florida, Department of Children and Families, *Community-Based Care Implementation Plan*, July 1999, pg. 2
[2] *Id.*
[3] *See* s. 2, Ch. 2009-206, L.O.F.
[4] Lead Agency Map, State of Florida, Department of Children and Families, at http://www.dcf.state.fl.us/programs/cbc/docs/lead_agency_map.pdf (last visited March 21, 2011).
[5] Section 409.1671(1)(h), (j), F.S.
[6] Section 409.1671(1)(l), F.S.
[7] Section 409.1671(1)(h) and (j), F.S.
[8] *See, e.g.*, s. 766.202(3), F.S., defining "economic damages" as financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, past and future medical expenses, wage loss, loss of future earnings capacity, funeral expenses, and loss of prospective net accumulations of an estate.
[9] The original limit on economic damages was set at $1,000,000.00 in Chapter 2009-206, L.O.F. The current limit on economic damages includes the annual 5 percent increase allowed by law.
[10] *See, e.g.*, s. 766.202(8), F.S., defining "non-economic damages" as non-financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, pain and suffering, loss of support and services, loss of companionship or consortium, inconvenience, physical impairment, mental anguish, disfigurement, and loss of capacity for enjoyment of life.
[11] The original limit on non-economic damages was set at $200,000.00 in Chapter 2009-206, L.O.F. The current limit on non-economic damages includes the annual 5 percent increase allowed by law.
[12] Section 409.1671(h) and (j), F.S.
[13] Section 409.1671(h), F.S.
[14] Section 409.1671(j), F.S.

According to industry advocates, lead agencies collectively paid approximately $2,750,000 in insurance premiums in 2010.[15] Given the fact that each lead agency contracts with many subcontractors to directly provide services and the fact that each subcontractor must maintain the same insurance coverage levels as the lead agency, it can reasonably be concluded that subcontractors are paying much more in insurance premiums than the combined amount paid by all twenty lead agencies. It can also be reasonably concluded that the total amount of insurance premiums paid by both lead agencies and subcontractors to maintain the statutorily mandated coverage is significant.

There is some indication, through anecdotal evidence, that tort claims against lead community-based providers, and subcontractors of the providers, are increasing.[16] One possible reason for the increase in claims is the high liability insurance requirement, which guarantees a significant source of recovery for a plaintiff in a tort case, assuming the plaintiff can obtain a favorable verdict. Also, the statute of limitations for intentional torts based on abuse can be lengthy, leaving a lead community-based provider, or subcontractor of the provider, liable for potentially significant damages over an extended period of time.[17]

Effect of Proposed Changes

The bill reduces the mandatory general liability insurance coverage requirement for lead agencies and subcontractors by half, to $500,000 per claim and a policy limit aggregate of $1,500,000. The limit on economic damages available to a claimant is reduced to $500,000, and capped at $1,500,000 for all claimants per incident. The total amount of economic damages recoverable by all claimants is limited to $2,000,000 against a lead agency and all subcontractors involved in the same incident.

The bill also limits non-economic damages available to a claimant to $200,000 per claimant and $500,000 per incident. The total amount of non-economic damages recoverable by all claimants is limited to $1,000,000 against a lead agency and all subcontractors involved in the same incident.

The bill repeals s. 409.1671(1)(l), F.S., eliminating the 5 percent annual increase in the conditional limitations on damages.

The bill adds language to s. 409.1671(2)(a), F.S., to state that DCF is not liable in tort for the acts or omissions of a lead agency, or a subcontractor of a lead agency, or the officers, agents, or employees of a lead agency, or subcontractor of a lead agency. The department may not require a lead agency or subcontractor of a lead agency to indemnify the department for its own acts or omissions. Lastly, the department may not require a lead agency or subcontractor to include the department as an additional insured on any insurance policy.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.1671, F.S., relating to foster care and related services; outsourcing.

Section 2: Provides an effective date of July 1, 2011.

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[15] *See* A Premium on Care: The Importance of Providing Affordable Insurance Coverage to Florida's Community-Based Care Agencies, Cynthia S. Tunnicliff, et al., at pg. 6, citing data provided by the Florida Coalition for Children.

[16] *Id.*

[17] Section 95.11, F.S., which, in part, provides for limitations on actions in tort, ranging from four years for actions founded on negligence or statutory liability [s. 95.11(3)(a) and (f), F.S.] to at least seven years, with a possibility of many years beyond, for intentional torts based on abuse [s. 95.11(7), F.S.].

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Lower liability limits could encourage insurers to enter, or re-enter, the market in Florida, creating competition for business and allowing lead agencies and subcontractors to maximize their premium dollars. Lead agencies and subcontractors should realize savings on insurance premiums.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

DAMAGES CAPS - This bill caps the economic and non-economic damages recoverable in certain tort actions. The Florida Constitution places limits on the Legislature's ability to cap damages in tort cases or otherwise restrict a litigant's access to courts. The "access to courts provision" of the declaration of rights in the Florida Constitution requires that the courts "be open to every person for redress of any injury".[18]

In Kluger v. White,[19] the Florida Supreme Court considered a statute which abolished causes of action to recover for property damage caused by an automobile accident unless the damage exceeded $550.[20] The court held that the statute violated the access to courts provision of the state

[18] Article I, s. 21, Fla. Const.
[19] 281 So.2d 1 (Fla. 1973).
[20] See Kluger, 281 So.2d at 2-3.

constitution. In Kluger, the court held that where a right to access to the courts for redress for a particular injury predates the adoption of the declaration of rights in the 1968 state constitution, the Legislature cannot abolish the right without providing a reasonable alternative unless the Legislature can show (1) an overpowering public necessity to abolish the right and (2) no alternative method of meeting such public necessity.[21]

The court applied the Kluger test in Smith v. Department of Insurance.[22] In 1986, the Legislature passed comprehensive tort reform legislation that included a cap of $450,000 on noneconomic damages. The Florida Supreme Court held that the right to sue for unlimited economic damages existed at the time the constitution was adopted.[23] The court said that a cap on noneconomic damages must meet the Kluger test in order to pass constitutional muster.[24] The Smith court held that the Legislature did not provide an alternative remedy or commensurate benefit in exchange for limiting the right to recover damages and found that the cap on noneconomic damages violated the access to courts provision of the Florida Constitution.[25]

The issue of caps on noneconomic damages arose again in University of Miami v. Echarte.[26] In 1988, the Legislature instituted a voluntary binding arbitration process in medical malpractice cases. The Florida Supreme Court applied the Kluger test and found that arbitration statute provided a commensurate benefit for the loss of the right to recover full noneconomic damages.[27] In addition, the Echarte court found that the Legislature had shown an overpowering public necessity for instituting the caps and that there was no reasonable alternative.[28]

The arbitration statute at issue in Smith states that damages are capped at $250,000 "per incident." In St. Mary's Hospital, Inc. v. Phillipe,[29] the Florida Supreme Court considered whether the "per incident" language meant that each claimant could recover the full $250,000 or whether all claimants in a single incident must divide $250,000. The court held that the statute meant that each claimant was entitled to recover up to $250,000 per incident.[30] To hold otherwise, the court said, would raise equal protection concerns because a claimant's recovery would be limited simply because there were multiple claimants in a given case.[31]

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

[21] See Kluger, 281 So.2d at 4.
[22] 507 So.2d 1080 (Fla. 1987).
[23] See Smith, 507 So.2d at 1087
[24] See Smith, 507 So.2d at 1087-1088.
[25] See Smith, 507 So.2d at 1089.
[26] 618 So.2d 189 (Fla. 1993).
[27] See Echarte, 618 So.2d at 194.
[28] See Echarte, 618 So.2d at 195-97.
[29] 769 So.2d 961 (Fla. 2000).
[30] See St. Mary's, 769 So.2d at 967-971.
[31] See St. Mary's, 769 So.2d at 971-973.

A bill to be entitled

An act relating to foster care providers; amending s. 409.1671, F.S.; decreasing the limits of liability and requisite insurance coverage for lead community-based providers and subcontractors; providing immunity from liability for the Department of Children and Family Services for acts or omissions of a community-based provider or subcontractor, or the officers, agents, or employees thereof; providing an effective date.

WHEREAS, lead community-based providers were established to provide foster care and related services, and

WHEREAS, the goal of establishing these providers was to strengthen the support and commitment of communities to the reunification of families and the care of children and families and to increase the efficiency and accountability of providers, and

WHEREAS, lead community-based providers provide services identical to those previously provided by the Department of Children and Family Services, which was protected when delivering those services by the state's sovereign immunity limits, and

WHEREAS, the costs of litigation and attorney's fees diminishes the resources available to the children and families served by lead community-based providers, and

WHEREAS, the Legislature finds that the limits of liability for lead community-based providers should be reviewed, NOW, THEREFORE,

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

Section 1. Paragraphs (f), (h), (j), and (l) of subsection (1) and paragraph (a) of subsection (2) of section 409.1671, Florida Statutes, are amended to read:

409.1671 Foster care and related services; outsourcing.—

(1)

(f)1. The Legislature finds that the state has traditionally provided foster care services to children who have been the responsibility of the state. As such, foster children have not had the right to recover for injuries beyond the limitations specified in s. 768.28. The Legislature has determined that foster care and related services need to be outsourced pursuant to this section and that the provision of such services is of paramount importance to the state. The purpose for such outsourcing is to increase the level of safety, security, and stability of children who are or become the responsibility of the state. One of the components necessary to secure a safe and stable environment for such children is that private providers maintain liability insurance. As such, insurance needs to be available and remain available to nongovernmental foster care and related services providers without the resources of such providers being significantly reduced by the cost of maintaining such insurance. To ensure that these resources are not significantly reduced, specified limits of liability are necessary for eligible lead community-based providers and subcontractors engaged in the provision of

services previously performed by the Department of Children and Family Services.

2. The Legislature further finds that, by requiring the following minimum levels of insurance, children in outsourced foster care and related services will gain increased protection ~~and rights of recovery in the event of injury than provided for in s. 768.28~~.

(h) Other than an entity to which s. 768.28 applies, any eligible lead community-based provider, as defined in paragraph (e), or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of $500,000 ~~$1 million~~ per claim with a policy limit aggregate of~~/~~ $1.5 ~~$3~~ million ~~per incident~~ in general liability insurance coverage. The eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per claim, $300,000 per incident, on their personal automobiles. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household but only while the automobiles are used in connection with the provider's

business. The nonowned automobile coverage for the provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of $1 million in nonowned automobile coverage. In any tort action brought against such an eligible lead community-based provider or employee, net economic damages shall be limited to $500,000 ~~$1 million~~ per liability claim, $1.5 million per liability incident, and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against an eligible lead community-based provider, the total economic damages recoverable by all claimants shall be limited to no more than $2 million against all lead agencies and subcontractors involved in the same incident or occurrence, when totaled together. In any tort action brought against such an eligible lead community-based provider, noneconomic damages shall be limited to $200,000 per claim and $500,000 per incident. In any tort action brought against an eligible lead community-based provider, the total noneconomic damages recoverable by all claimants shall be limited to no more than $1 million against all subcontractors and lead agencies involved in the same incident or occurrence, when totaled together. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any

offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76. The lead community-based provider is ~~shall~~ not ~~be~~ liable in tort for the acts or omissions of its subcontractors or the officers, agents, or employees of its subcontractors.

(j) Any subcontractor of an eligible lead community-based provider, as defined in paragraph (e), which is a direct provider of foster care and related services to children and families, and its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability insurance coverage for a minimum of $500,000 ~~$1 million~~ per claim with a policy limit aggregate of~~/~~ $1.5 ~~$3~~ million ~~per incident~~ in general liability insurance coverage. The subcontractor of an eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of $100,000 per claim, $300,000 per incident, on their personal automobiles. In lieu of personal motor vehicle insurance, the subcontractor's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned

automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor shall be primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of $1 million in nonowned automobile coverage. In any tort action brought against such subcontractor or employee, net economic damages shall be limited to $500,000 ~~$1 million~~ per liability claim, $1.5 million per liability incident, and $100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such subcontractor or employee, the total economic damages recoverable by all claimants shall be limited to no more than $2 million against all subcontractors and lead agencies involved in the same incident or occurrence, when totaled together. In any tort action brought against such subcontractor, noneconomic damages shall be limited to $200,000 per claim and $500,000 per incident. In any tort action brought against such subcontractor or employee, the total noneconomic damages recoverable by all claimants shall be limited to no more than $1 million against all subcontractors and lead agencies involved in the same incident or occurrence, when totaled together. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall

be in accordance with s. 768.76.

~~(1) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2)(a) The department may contract for the delivery, administration, or management of protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate. The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services~~ are of high quality and delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of an eligible lead community-based provider or the officers, agents, or employees of the provider, nor is the department liable in tort for the acts or omissions of the subcontractors of eligible lead community-based providers or the officers, agents, or employees of its subcontractors. The department may not require an eligible lead community-based provider or its subcontractors to indemnify the department for the department's own acts or omissions, nor may the department require an eligible lead community-based provider or its subcontractors to include the department as an additional

insured on any insurance policy. The department must adopt written policies and procedures for monitoring the contract for delivery of services by lead community-based providers. These policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract for services of lead community-based providers are communicated to the director of the provider agency as expeditiously as possible.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1237 Legal and Medical Referral Service Advertising
SPONSOR(S): Kriseman
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1918

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee		Billmeier LMB	Bond MB
2) Business & Consumer Affairs Subcommittee			
3) Judiciary Committee			

SUMMARY ANALYSIS

Currently, advertising by lawyers is regulated by rules created by the Florida Supreme Court. Entities that may refer cases to lawyers for a fee are not subject to the same advertising restrictions. This bill creates restrictions on advertising by lawyer referral services and medical referral services in motor vehicle accident cases. This bill creates a prohibition on false, misleading, or deceptive communication. It defines false, misleading, or deceptive communications in a manner similar to the current rules that apply to lawyer advertisements. This bill requires that an advertisement by or on behalf of a lawyer referral service relating to motor vehicle accidents contain a statement explaining that the advertisement is for a lawyer referral service that is receiving a fee from attorneys for referrals.

This bill requires that advertisements for legal services related to motor vehicle accidents distributed by a lawyer referral service must comply with the Rules Regulating the Florida Bar. This bill requires lawyer referral services to submit advertisements to the Florida Bar. Attorneys are already required by Bar rule to submit advertisements to the Florida Bar for approval prior to publication.

This bill requires that a lawyer referral service or medical referral service disclose its financial relationship with any lawyers or health care providers to the persons it refers to such lawyers or health care providers. This bill prohibits a lawyer referral service from requiring a participating lawyer to recommend the services of a particular health care provider or other professional as a condition of participation in the referral service. This bill provides that a medical referral service may not make referrals only to a medical clinic or health care provider with which the medical referral service has a financial or ownership interest.

This bill requires that a person that violates the provisions of the bill to forfeit any money received as a result of an advertisement that violates the provisions of the bill. In addition, a person that violates the provisions of the bill is subject to a civil penalty of $1,000 for the first offense and $5,000 for each subsequent offense.

This bill creates a civil cause of action for violations of the provision of the bill. It allows a person to file a complaint with the Department of Agriculture and Consumer Services. If the department does not initiate legal proceedings within 90 days, the person who filed the complaint may seek to enforce penalties. A person who files an action may recover attorney's fees and costs, penalties, and may recover 25 percent of all moneys paid as a civil penalty. Further, any person injured by a violation of this bill may bring an action for recovery of damages. A judgment in favor of the person shall be for actual damages, and the losing party is liable for the person's reasonable attorney's fees and costs. This bill provides for misdemeanor criminal penalties for some violations.

This bill appears to have an indeterminate fiscal impact on state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Florida Bar is the entity that regulates lawyers in Florida. The Florida Bar was created by the Florida Supreme Court to govern the regulation of attorneys.[1] The court has promulgated a set of rules, called the Rules Regulating the Florida Bar, to regulate attorneys. The rules include rules and procedures relating to advertising by attorneys. The rules set forth permissible forms of advertising by lawyers,[2] required content of advertisements, permissible content of advertisements,[3] and require evaluation of advertisement by the Florida Bar staff for compliance with the rules.[4]

Lawyer referral services are defined by Florida Bar rules as:

> Any person, group of persons, association, organization, or entity that receives any consideration, monetary or otherwise, given in exchange for referring or causing the direct or indirect referral of a potential client to a lawyer selected from a specific group or panel of lawyers; or
>
> Any group or pooled advertising program operated by any person, group of persons, association, organization, or entity wherein the legal services advertisements utilize a common telephone number and potential clients are then referred only to lawyers or law firms participating in the group or pooled advertising program.[5]

A pro bono referral program is not a lawyer referral service for purposes of the rule.[6] Some lawyer referral services refer potential clients to lawyers for fee. Others do not involve a fee and may be operated by local bar associations or legal aid organizations.

Rule 4-7.2(c), Rules Regulating the Florida Bar, provides that a lawyer may not make a false, misleading, or deceptive communication about the lawyer or the lawyer's services. The rule provides that a communication or advertisement violates the rule if it:

- Contains a material misrepresentation of fact or law;
- Is false or misleading;
- Fails to disclose material information necessary to prevent the information supplied from being false or misleading;
- Is unsubstantiated in fact;
- Is deceptive;
- Contains any reference to past successes or results obtained;
- Promises results;
- States or implies that the lawyer can achieve results by means that violate the Rules of Professional Conduct or other law;
- Compares the lawyer's services with other lawyers' services, unless the comparison can be factually substantiated; or
- Contains a testimonial.

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[1] http://www.floridasupremecourt.org/pub_info/system2.shtml
[2] *See* Rule 4-7.1, Rules Regulating the Florida Bar.
[3] *See* Rules 4.7.2(a) and (b), Rules Regulating the Florida Bar.
[4] *See* Rule 4-7.7, Rules Regulating the Florida Bar.
[5] Rule 4-7.10(c), Rules Regulating the Florida Bar.
[6] Rule 4-7.10(c), Rules Regulating the Florida Bar.

Rule 4-7.10(a)(1), Rules Regulating the Florida Bar, requires lawyers not to accept referrals from a lawyer referral services unless the service "engages in no communication with the public... in a manner that would violate the Rules of Professional Conduct."

The Rules Regulating the Florida Bar apply to lawyers but do not apply to lawyer referral services.

Effect of this Bill

The Florida Bar rules provide restrictions on lawyer advertising. This bill imposes similar restrictions on lawyer referral and medical referral services.

This bill contains "whereas" clauses to demonstrate why the bill is necessary. This bill includes legislative findings that:

- There have been numerous complaints concerning misleading and deceptive advertisements directed to motor vehicle accident victims by lawyer and medical referral services;
- It is important for the public to have an absolute trust in public safety officers and officials it is in the best interest and welfare of the state that the image, representation, and likeness of public safety officers and officials not be used in a deceptive and misleading manner;
- The public has been misled and deceived by health care provider clinics and entities claiming to be medical referral services and lawyer referral services that advertise using catchy slogan without disclosing that they represent a specific law firm or health care provider; and
- The Rules Regulating The Florida Bar concerning lawyer advertisements are for the express purpose of protecting the public from misleading or deceptive advertising by lawyers so it is necessary to adopt a broader approach to the protection of the public from false and deceptive advertising to motor vehicle accident victims.

This bill provides that it is cumulative and does not amend or repeal any other valid law, code, ordinance, rule, or penalty.

Definitions

This bill creates new sections of law to regulate advertising by lawyer referral services and medical referral services. The bill defines "lawyer referral service" as:

> Any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose clients or prospective clients are referred only to lawyers or law firms participating in the group or pooled advertising program.

This definition is substantially similar to the definition for lawyer referral service contained in Rule 4-7.10(c), Rules Regulating the Florida Bar. Certain not-for-profit lawyer referral programs, lawyer referral programs operated by voluntary bar associations, and lawyer referral programs recognized by the Florida Bar are exempt from the requirements of this bill.

This bill provides a similar definition for "medical referral service" as:

> Any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal and medical services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose patients or prospective patients are referred only to medical clinics or health care providers participating in the group or pooled advertising program.

Advertising Rules for Lawyer Referral Services and Medical Referral Services

This bill requires that all advertising on behalf of a medical or lawyer referral service relating to injuries from a motor vehicle accident must, if the advertisement includes any reference to a person as a health care provider, lawyer, or law firm, disclose the counties in which the health care provider, lawyer, or law firm has a bona fide office from which services will be provided.

This bill provides that each advertisement cannot include any false, misleading, or deceptive communication. A communication violates the provisions of this bill if it:

- Contains a material misrepresentation of fact;
- Fails to disclose material information necessary to prevent the information supplied from being false or misleading;
- Claims facts that cannot be substantiated;
- Contains any reference to past results obtained that would deceive the public into having unjustified expectations. This bill requires a disclaimer that "results will vary depending on the specific facts" for any reference to past results and requires that the disclaimer be communicated in the same manner as any reference to past results;
- Contains a reference to monetary amounts that create unjustified expectations when there is no factual basis to suggest such monetary amounts to the general public;
- Promises or suggests a specific result that cannot be guaranteed;
- Contains any testimonial by an actor, unless such testimonial includes a disclaimer, communicated in the same manner as the testimonial, that the testimonial is not a true story and the person providing the testimonial is an actor and not a real person;
- Contains any testimonial by a real person, unless such person actually obtained the services of the person or entity advertising the services, and the testimonial is completely truthful and verifiable, and includes the disclaimer that "results may vary depending on the specific facts." The disclaimer must be communicated in the same manner as the real person testimonial; and
- Contains any verbal or visual reference to any connection between any person in public safety, or purporting to be in public safety. This prohibition includes the use of any public safety badge, emblem, uniform, hat, vehicle, or any replica of any such item. An exception to this prohibition is when the person in charge of a public safety entity gives express written consent to the use of the reference to such agency in the advertisement or communication.[7]

These restrictions are similar to restrictions contained in the Rules Regulating the Florida Bar relating to lawyer advertising.

A person who violates these provisions commits an unfair or deceptive trade practice as defined in part II of chapter 501, F.S.

Advertisements Must Comply with Supreme Court Rules

This bill requires that an advertisement or unsolicited written communication for legal services related to motor vehicle accidents distributed by or on behalf of any lawyer referral service must comply with the Supreme Court of Florida's Rules Regulating The Florida Bar pertaining to lawyer referral and advertising services as if those services were provided by members of The Florida Bar. This bill provides an exception for lawyer referral services operated by a voluntary bar association or legal aid program recognized by The Florida Bar.

Certain Advertisements Must be Submitted to the Florida Bar

This bill requires that each advertisement by or on behalf of a lawyer referral service related to motor vehicle accidents be filed with The Florida Bar, accompanied by an affidavit signed under oath by the

[7] Restrictions on advertising are sometimes challenged as a violation of the First Amendment. *See* III.A.2. Constitutional Issues in this analysis

owner, shareholder, principal, or officer of the referral service affirming under penalty of perjury that the person:

- Has read and understands the Supreme Court of Florida's Rules Regulating The Florida Bar, which pertain to lawyer referral and advertising services;
- Acknowledges that he or she is the person responsible for the advertisement and for the adverse consequences of any prohibited advertising, including those within this act;
- Affirms that the advertisement complies with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising; and
- Acknowledges that a knowing violation of the Supreme Court Florida's Rules Regulating The Florida Bar, which govern lawyer advertising, subjects the person to a civil penalty of $1,000 for the first offense and a civil penalty of $5,000 for each subsequent offense.

The person must also affirm that he or she:

- Has filed the advertisement for review with The Florida Bar in compliance with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising;
- Is responsible for filing and will file the advertisement for review with The Florida Bar in compliance with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising; or
- Has determined that the advertisement is exempt from the filing requirement as set forth in the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising.

The affidavit must be submitted to The Florida Bar and maintained by the referral services for 2 years.

Additional Required Notices in Advertisements

This bill requires that an advertisement or unsolicited written communication by or on behalf of a lawyer referral service relating to motor vehicle accidents must contain the statement: "This advertisement is by a lawyer referral service. Lawyers may pay this service for referrals of prospective clients who respond to this advertisement. This lawyer referral service is not licensed to provide legal services in Florida."

Additional Requirements on Lawyer and Medical Referral Services

This bill requires that if a person that advertises the service of referring motor vehicle accident victims to a health care provider or lawyer refers a person to a health care provider or lawyer, the referring person must provide the person referred with a written disclosure that states any financial interest or financial relationship that the referring person has with the health care provider or lawyer.

This bill prohibits a lawyer referral service from requiring a participating lawyer to recommend the services of a particular health care provider or other professional as a condition of participation in the referral service.

This bill requires that a medical referral service may not make referrals only to a medical clinic or health care provider with which the medical referral service has any financial or ownership interest.

Civil and Criminal Penalties for Violations

This bill requires that a person who violates the provisions of the bill forfeits any money received as a result of an advertisement that violates the provisions of the bill. In addition, a person who violates the provisions of the bill is subject to a civil penalty of $1,000 for the first offense and $5,000 for each subsequent offense.

This bill creates a civil cause of action. A person who claims a violation may file a complaint with the Department of Agriculture and Consumer Services. If the department fails to initiate legal proceedings within 90 days after receiving the complaint, the person who filed the complaint may seek to enforce

penalties and may seek an injunction. A person who files an action may recover attorney's fees and costs, penalties, and may recover 25 percent of all moneys paid as a civil penalty as a result of such person's action This bill provides that each prohibited advertisement is a separate offense. Further, any person injured by a violation of this bill may bring an action for recovery of damages. A judgment in favor of the person shall be for actual damages, and the losing party is liable for the person's reasonable attorney's fees and costs.

The bill also provides criminal penalties. The first violation of the provisions of the bill is a civil offense. Any subsequent knowing violation is second degree misdemeanor. A second degree misdemeanor is punishable by up to 60 days in jail and a fine of $500.[8]

Effective Date

This bill is effective July 1, 2011.

B. SECTION DIRECTORY:

Section 1 creates definitions relating to lawyer referral services, medical referral services, and electronic media.

Section 2 provides restrictions on advertising related to motor vehicle accidents by medical and lawyer referral services.

Section 3 provides that advertising for legal services relating to motor vehicle accidents by lawyer referral services must comply with Supreme Court rules.

Section 4 provides that advertisements for lawyer referral services relating to motor vehicle accidents must be submitted to the Florida Bar.

Section 5 provides requirements for advertisements for lawyer referral services related to motor vehicle accidents.

Section 6 requires certain disclosures in advertisements relating to motor vehicle accidents by lawyer referral services or medical referral services.

Section 7 provides restrictions on referrals made by lawyer referral services.

Section 8 provides restrictions on referrals made by medical referral services.

Section 9 provides for civil penalties for violations of the provisions of the bill.

Section 10 provides for criminal penalties for violations of the provisions of the bill.

Section 11 provides that provisions of the bill are cumulative to other law.

Section 12 provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Indeterminate. See "Fiscal Comments."

[8] *See* ss. 775.082, 775.083, F.S.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

This bill imposes new requirements on advertising by lawyer referral services and medical referral services. The fiscal impact of these new requirements is not known.

This bill imposes civil and criminal penalties on offenders. Civil penalties will result in state revenues while criminal penalties will result in local government costs for jailing offenders. It is unknown how many persons would violate the provisions of this bill. It is anticipated that the revenues and expenditures of this bill would not be significant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

Freedom of Speech

The First Amendment of the United States Constitution, as applied to the states, limits the power of government to restrict speech. Article I, s. 4, Fla. Const., provides similar restrictions in the state constitution.

This bill provides for restrictions on advertising by lawyer referral services and medical referral services. If this bill is challenged, the court must determine whether the advertising at issue is protected by the free speech provisions and, if so, what level of scrutiny to apply. In case challenging restrictions on lawyer advertising, the United States Supreme Court explained:

> Mindful of these concerns, we engage in "intermediate" scrutiny of restrictions on commercial speech, analyzing them under the framework set forth in *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557 (1980). Under *Central Hudson*, the government may freely regulate commercial speech that concerns unlawful activity or is misleading. Commercial speech that falls into neither of those categories, like the advertising at issue here, may be regulated if the government satisfies a test consisting of three related prongs: First, the government must assert a substantial interest in support of its regulation; second, the government must demonstrate that the

> restriction on commercial speech directly and materially advances that interest; and third, the regulation must be "narrowly drawn."[9]

This bill completely prohibits "false, misleading, or deceptive" communications. Such speech is not protected by the First Amendment.[10]

Other restrictions in this bill must be analyzed by a court in light of the specific restriction. This bill restricts advertising which claims facts that cannot be substantiated.[11] This bill restricts references to "past successes" that could deceive the public or lead to unjustified expectations and restricts advertising that suggests a result that cannot be guaranteed.[12] Some provisions of this bill require disclaimers noting, for example, that an actor in an advertisement is an actor and not a real client or requiring a disclosure that results obtained may vary depending on specific facts. Courts have looked at disclaimer requirements and noted that requirements of disclaimers could be effective at prevent deception.[13] However, one court held a disclaimer requirement invalid because the requirement would "effectively rule out" the use of short television or radio advertisements.[14]

While courts have analyzed lawyer advertising provisions, the cases are fact-specific. In general, a court would apply the tests of *Central Hudson* and *Florida Bar* in determining whether these restrictions violated the First Amendment.

Commerce Clause

This bill potentially imposes regulations on lawyer referral and medical referral services that are not located in Florida. The Commerce Clause of the United States Constitution limits the ability of states to regulate commerce between the states. The United States Supreme Court describes the Commerce Clause as follows:

> The Commerce Clause and its nexus requirement are informed not so much by concerns about fairness for the individual defendant as by structural concerns about the effects of state regulation on the national economy. Under the Articles of Confederation, state taxes and duties hindered and suppressed interstate commerce; the Framers intended the Commerce Clause as a cure for these structural ills. It is in this light that we have interpreted the negative implication of the Commerce Clause.[15]

The Commerce Clause allows Congress to regulate commerce between the states. Dormant commerce clause analysis is a part of Commerce Clause analysis. The dormant commerce clause is the theory that, where Congress has not acted to regulate or deregulate a specific form of commerce between the states, it is presumed that Congress would prohibit unreasonable restrictions upon that form of interstate commerce.

Dormant Commerce Clause doctrine distinguishes between state regulations that "affirmatively discriminate" against interstate commerce and evenhanded regulations that "burden interstate transactions only incidentally."[16] Regulations that "clearly discriminate against interstate commerce [are] virtually invalid per se,"[17] while those that incidentally burden interstate commerce will be struck

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[9] *Florida Bar v. Went for It, Inc.*, 515 U.S. 618, 623-624 (1995)(internal citations edited or omitted).
[10] *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557 (1980).
[11] *See Alexander v. Cahill*, 598 F.3d 79, 89 (2d Cir. 2010)(holding that speech that is "irrelevant, unverifiable, and non-informational" is not inherently false, deceptive, or misleading).
[12] *See Alexander v. Cahill*, 598 F.3d 79, 92 (2d. Cir. 2010)(noting that disclaimers may be used to prevent potential clients from believing that past successes will indicate future results).
[13] *See e.g. Alexander v. Cahill*, 598 F.3d 79, 96 (2d. Cir. 2010)(invalidating an advertising restriction but noting that the state could have required disclaimers and nothing indicated that disclaimers would be ineffective).
[14] *Public Citizen, Inc. v. Louisiana Attorney Disciplinary Board*, 632 F.3d 212, 229 (2d Cir. 2010).
[15] *Quill Corp. v. North Dakota*, 504 U.S. 298, 312 (1992) (internal citations omitted).
[16] *Maine v. Taylor*, 477 U.S. 131, 138 (1986).
[17] *National Electric Manufacturers Association v. Sorrell*, 272 F.3d 104, 108 (2d Cir.2001),

down only if "the burden imposed on such commerce is clearly excessive in relation to the putative local benefits."[18]

State regulations may burden interstate commerce "when a statute (i) shifts the costs of regulation onto other states, permitting in-state lawmakers to avoid the costs of their political decisions, (ii) has the practical effect of requiring out-of-state commerce to be conducted at the regulating state's direction, or (iii) alters the interstate flow of the goods in question, as distinct from the impact on companies trading in those goods."[19]

If this bill were challenged as a violation of the Commerce Clause, the courts would have to consider whether any restrictions imposed by the bill are reasonable.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The acknowledgement that must be executed pursuant to lines 184-188 does not mention the potential criminal penalties that could be imposed against one who violates the provisions of the bill.

Line 260 of this bill refers to an "adjudication of guilt" but appears to be making that reference in the context of a civil action. "Adjudication of guilt" is a term used in the criminal law.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

n/a

[18] *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970).
[19] *Brown & Williamson Tobacco Corp. v. Pataki*, 320 F.3d 200, 208-09 (2d Cir.2003) (citations omitted).

A bill to be entitled

An act relating to legal and medical referral service advertising; providing definitions; requiring advertising from a medical or lawyer referral service related to motor vehicle accidents to comply with certain requirements regarding content; requiring advertisements or unsolicited written communications from certain legal referral services related to motor vehicle accidents to comply with the Supreme Court of Florida's Rules Regulating The Florida Bar; requiring that published advertisements from a lawyer referral service be filed with The Florida Bar along with an affidavit meeting certain criteria; requiring advertisements or unsolicited written communications from a lawyer referral service to display certain information; requiring a referring person or entity to provide certain financial information to the person referred to a lawyer or health care provider; prohibiting a lawyer referral service to condition membership based on certain criteria; prohibiting a medical referral service from making referrals only to a medical clinic or health care provider in which it has a financial or ownership interest; providing civil and criminal penalties for violations relating to legal and medical referral advertising and relief to persons affected; providing an effective date.

WHEREAS, there have been numerous complaints concerning misleading and deceptive advertisements directed to motor

vehicle accident victims by entities who advertise they are available to refer motor vehicle accident victims to lawyers and health care providers, and

WHEREAS, it is important for the public to have an absolute trust in public safety officers and officials, including but not limited to, firefighters, police officers, and paramedics, and, as such, it is in the best interest and welfare of the state that the image, representation, and likeness of public safety officers and officials not be used in a deceptive and misleading manner to falsely misrepresent to the public that such officers and officials are recommending that the public call a help-line for accident victims which is the phone number for either an auto accident clinic or an entity in business to refer motor vehicle accident victims to a specific health care provider clinic, lawyer, or law firm, and

WHEREAS, the public has been misled and deceived by health care provider clinics and entities claiming to be medical referral services and lawyer referral services that advertise using a catchy phone number or slogan and who represent themselves as an "Ask Us" informational service for motor vehicle accident victims, without disclosing they are really a front for a specific health care provider clinic, lawyer, or law firm, and

WHEREAS, the public should not be deceived and misled by false or deceptive advertising that is for the purpose of steering motor vehicle accident victims to a specific health care provider, lawyer, or law firm, and

WHEREAS, lawyer advertisements for motor vehicle accidents

are regulated by the Supreme Court of Florida's Rules Regulating The Florida Bar; however, those rules are not directly applicable to non-lawyer entities that advertise to motor vehicle accident victims and refer those victims to lawyers or law firms, and

WHEREAS, because the Supreme Court of Florida's Rules Regulating The Florida Bar concerning lawyer advertisements are for the express purpose of protecting the public from misleading or deceptive advertising by lawyers only, it is necessary to adopt the following broader approach to the protection of the public from false and deceptive advertising to motor vehicle accident victims, NOW, THEREFORE,

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

Section 1. As used in this act, the term:

(1) "Electronic media" includes, but is not limited to, computer-accessed, radio, and television advertisements.

(2) "Lawyer referral service" means any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose clients or prospective clients are referred only to lawyers or law firms participating in the group or pooled advertising program. A not-for-profit referral program in which participating lawyers do not pay a fee or charge of any kind to receive referrals or to belong to the referral panel and undertake the referred matters

without expectation of remuneration is not considered a lawyer referral service for purposes of this act. A lawyer referral service for or operated by a voluntary bar association or legal aid program recognized by The Florida Bar is exempt from the provisions of this act related to the regulation of legal and medical referral services advertising to motor vehicle accident victims.

(3) "Medical referral services" means any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal and medical services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose patients or prospective patients are referred only to medical clinics or health care providers participating in the group or pooled advertising program.

Section 2. All advertising by or on behalf of a medical or lawyer referral service to the general public for services related to injuries from a motor vehicle accident must comply with the following:

(1) If an advertisement includes any reference to referring a person to a health care provider, lawyer, or law firm, the advertisement must clearly disclose the county or counties in which the health care provider, lawyer, or law firm to whom the referral will be made has a bona fide office from which the services will be provided;

(2) Each advertisement is prohibited from including any false, misleading, or deceptive communication. A communication violates this subsection if it:

(a) Contains a material misrepresentation of fact.

(b) Fails to disclose material information necessary to prevent the information supplied from being false or misleading.

(c) Claims facts that cannot be substantiated.

(d) Contains any reference to past successes or results obtained that would deceive the public into having unjustified expectations. For purposes of this act, a disclaimer that "results will vary depending on the specific facts" is required for any reference to past successes or results, and such disclaimer shall be communicated in the exact same manner as any reference to past successes or results.

(e) Contains a reference to monetary amounts that create unjustified expectations, such as using deceptive statements like "Don't make a million dollar mistake." or "You may be entitled to $100,000." when there is no factual basis to suggest such monetary amounts to the general public.

(f) Promises or suggests a specific result that cannot be guaranteed, including promising or suggesting a monetary result that cannot be guaranteed.

(g) Contains any testimonial by an actor, unless such testimonial includes a disclaimer, communicated in the exact same manner as the testimonial, that the testimonial is not a true story and the person providing the testimonial is an actor and not a real person.

(h) Contains any testimonial by a real person, unless such person actually obtained the services of the person or entity advertising the services, and the testimonial is completely truthful and verifiable, and includes the disclaimer that

"results may vary depending on the specific facts." Such disclaimer shall be communicated in the exact same manner as the real person testimonial.

(i) Contains any verbal or visual reference, from the past or in the present, to any connection between any person in public safety, or purporting to be in public safety, or any public safety entity that has any connection of any kind to the person or entity advertising the services to motor vehicle accident victims. This prohibition includes the use of any visual or verbal reference to any actor purporting to be connected in any way to a public safety officer or public safety entity. This prohibition includes the use of any public safety badge, emblem, uniform, hat, vehicle, or any replica of any such item. An exception to this prohibition is when the person in charge of a public safety entity gives express written consent to the use of the reference to such agency in the advertisement or communication.

Section 3. An advertisement or unsolicited written communication for legal services related to motor vehicle accidents disseminated in this state by or on behalf of any lawyer referral service, other than a lawyer referral service for or operated by a voluntary bar association or legal aid program recognized by The Florida Bar, must comply with the Supreme Court of Florida's Rules Regulating The Florida Bar pertaining to lawyer referral and advertising services as if those services were provided by members of The Florida Bar, including filing requirements.

Section 4. (1) Each advertisement by or on behalf of a

lawyer referral service related to motor vehicle accidents that is submitted for publication in the print or electronic media or on a billboard in this state must at the same time be filed with The Florida Bar, accompanied by an affidavit signed under oath by the owner, shareholder, principal, or officer of the referral service affirming under penalty of perjury that the person:

(a) Has read and understands the Supreme Court of Florida's Rules Regulating The Florida Bar, which pertain to lawyer referral and advertising services;

(b) Acknowledges that he or she is the person responsible for the advertisement and for the adverse consequences of any prohibited advertising, including those within this act;

(c) Affirms that the advertisement complies with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising;

(d) Acknowledges that a knowing violation of the Supreme Court Florida's Rules Regulating The Florida Bar, which govern lawyer advertising, subjects the person to a civil penalty of $1,000 for the first offense and a civil penalty of $5,000 for each subsequent offense; and

(e) Affirms that the person:

1. Has filed the advertisement for review with The Florida Bar in compliance with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising;

2. Is responsible for filing and will file the advertisement for review with The Florida Bar in compliance with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising; or

3. Has determined that the advertisement is exempt from the filing requirement as set forth in the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising.

(2) A copy of the affidavit must be submitted to The Florida Bar and maintained by the referral services for 2 years.

Section 5. An advertisement or unsolicited written communication disseminated in this state by or on behalf of a lawyer referral service relating to motor vehicle accidents must contain prominently within the body of the advertisement or unsolicited written communication the statement: "This advertisement is by a lawyer referral service. Lawyers may pay this service for referrals of prospective clients who respond to this advertisement. This lawyer referral service is not licensed to provide legal services in Florida."

Section 6. When a person or entity that advertises the service of referring motor vehicle accident victims to a health care provider, lawyer, or law firm refers a person to a health care provider, lawyer, or law firm, the referring person or entity must provide the person referred with a written disclosure that clearly and unambiguously states any financial interest or financial relationship that the referring person or entity has with the health care provider, lawyer, or law firm to whom a referral is made. A copy of the written disclosure must be submitted to The Florida Bar and maintained by the referral service for 2 years.

Section 7. A lawyer referral service may not require a participating lawyer or law firm to recommend the services of a

particular health care provider or other professional as a condition of participation in the referral service.

Section 8. A medical referral service may not make referrals only to a medical clinic or health care provider with which the medical referral service has any financial or ownership interest.

Section 9. (1)(a) A person or entity that violates this act shall forfeit any monetary amount received as a result of an advertisement that violates this act.

(b) A person or entity that violates this act is subject to a civil penalty of $1,000 for the first offense and $5,000 for each subsequent offense.

(c) Any sums collected as a civil penalty under this subsection shall be deposited in the State Courts Revenue Trust Fund.

(2) A person who claims a violation of this act may file a complaint with the Department of Agriculture and Consumer Services. If the department fails to initiate legal proceedings within 90 days after receiving the complaint, the person who filed the complaint may, in a court of competent jurisdiction, seek to enforce such penalties and may seek an injunction against the person in violation of this act. The right of a person to initiate court proceedings is limited to the person who first filed the complaint with the department on each individual violation.

(3) A person who files a court action pursuant to this act may recover attorney's fees and costs if successful in obtaining an injunction, penalties, or both and may recover 25 percent of

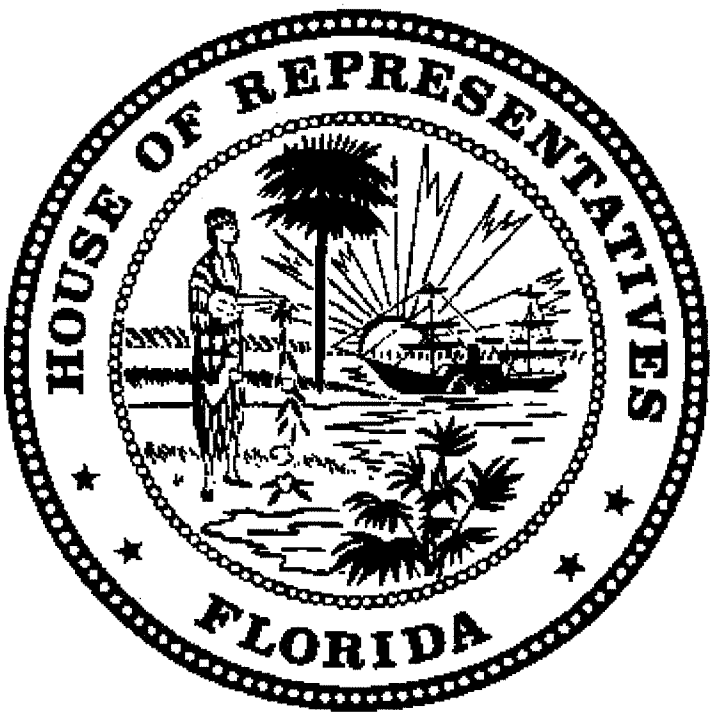
all moneys paid as a civil penalty as a result of such person's action to enforce this act, whether in court or through the actions of the department.

(4) Each prohibited advertisement that appears on a billboard, is published in print media, airs on radio or television, or appears on a computer website controlled by the party advertising the services constitutes a separate offense.

Section 10. After an adjudication of guilt is entered for a first offense of violating this act, any subsequent knowing violation of this act is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. A person who violates section 2 of this act commits an unfair or deceptive trade practice as defined in part II of chapter 501 and is subject to the penalties and remedies provided therein. Further, any person injured by a violation of this act may bring an action for recovery of damages. A judgment in favor of the person shall be for actual damages, and the losing party is liable for the person's reasonable attorney's fees and costs.

Section 11. This act is cumulative and does not amend or repeal any other valid law, code, ordinance, rule, or penalty now in effect.

Section 12. This act shall take effect July 1, 2011.



Civil Justice Subcommittee

Wednesday, March 23, 2011
8:00 AM
404 HOB

AMENDMENT PACKET

Dean Cannon
Speaker

Eric Eisnaugle
Chair

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Civil Justice Subcommittee
Representative(s) Goodson offered the following:

Amendment (with title amendment)

Remove line 23 and insert:

spaceflight activities. This also includes any manufacturer or supplier of components, services, or vehicles that have been reviewed by the United States Federal Aviation Administration as part of issuing such a license, permit, or authorization.

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

Remove line 3 and insert:

amending s. 331.501, F.S.; providing immunity from liability for certain manufacturers or suppliers; saving a provision from future

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Civil Justice Subcommittee
Representative(s) Horner offered the following:

Amendment

Remove lines 170-176 and insert:

f. For all other medical services, ~~supplies, and care,~~ 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For all other supplies and care, including durable medical equipment and care and services rendered by ambulatory surgical centers and by clinical laboratories, 200 percent of the allowable amount under Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Civil Justice Subcommittee
Representative(s) Horner offered the following:

Amendment

Remove lines 354-364 and insert:

subsections (10) and (15) and except that any attorney's fees recovered are limited to the lesser of $200 per billable hour or:

(a) For any disputed amount of less than $500, fifteen times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $5,000;

(b) For any disputed amount of $500 or more and less than $5,000, ten times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $10,000; or

(c) For any disputed amount of $5,000 or more and up to $10,000, five times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $15,000.

(17) CLASS ACTIONS.—Attorney's fees in a class action under ss. 627.730-627.7405 are limited to the lesser of $50,000 or three times the total of any disputed amount recovered in the class action proceeding.

(18) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the attorney's fees recovered under ss. 627.730-627.7405 shall be calculated without regard to any contingency risk multiplier.

(19) ARBITRATION.—In order to provide for an expedited,

Amendment No. 3

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Civil Justice Subcommittee
Representative(s) Horner offered the following:

Amendment

Remove lines 384-414 and insert:

arbitrator. The Department of Financial Services shall adopt by rule procedures to implement this arbitration program including:

1. Reasonable requirement for processing and scheduling of requests for arbitration;

2. Qualifications of arbitrators;

3. Selection of arbitrators;

4. Fees charged by arbitrators; and

5. Criteria for conduct of arbitration.

(d)1. The claimant shall make available for inspection or copying the medical and other records on which the claimant intends to rely at arbitration, upon written request by the insurer or his or her attorney, within 15 days after receipt of such request.

2. The insurer shall make available for inspection or copying all documents, records, or information upon which it is relying in adjusting or rejecting the claim, upon written request by the claimant or his or her attorney, within 10 days after receipt of such request.

3. Discovery of insurer documents, records, or information shall be limited to those relating to insurance coverage. The insurer is not required to produce claims-privileged items, underwriting files, or documents that it does not intend to rely on at arbitration.

4. There shall be no discovery relating to general claims-handling practices.

(e) The decision of the arbitrator shall be set forth in writing and furnished to each party within 30 days after the arbitration. The decision shall be binding on each party unless challenged pursuant to paragraph (g). An arbitration award may not exceed the applicable limits of coverage remaining on the policy.

(f) The claimant is entitled to reimbursement of attorney's fees directly associated with the arbitration, subject to subsection (8). The award of fees must be set forth in the arbitration decision. The insurer is responsible for payment of the arbitrator fees and expenses, court reporter fees and any facility fees associated with the arbitration proceedings. All costs and other expenses incurred during the preparation, discovery and arbitration proceedings shall be paid by the parties incurring the expenses.

Amendment No. 4

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Civil Justice Subcommittee
Representative(s) Gaetz offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation under this section must be sent via United States certified mail to the registered agent of the disclosing entity.

Section 2. Paragraph (a) of subsection (5) of section 627.736, Florida Statutes, is amended to read:

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

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)1. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection

insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

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

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

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

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

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

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

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

4. Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits or any payment limitations that apply under Medicare or workers' compensation. An insurer that applies the ~~allowable~~ payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not

covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

Section 3. Subsection (1) of section 316.066, Florida Statutes, is amended to read:

316.066 Written reports of crashes.—

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

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

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

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

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

(b) The long form must include:

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

2. A description of the vehicles involved.

3. The names and addresses of the parties involved.

4. The names and addresses of witnesses.

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

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

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

(c) ~~(b)~~ In every crash for which a Florida Traffic Crash Report, Long Form, is not required ~~by this section~~, the law enforcement officer may complete a short-form crash report or provide a short-form crash report to be completed by each party involved in the crash. The short-form report must include all of the items listed in subparagraphs (b)1.-6. Short-form crash reports prepared by the law enforcement officer shall be maintained by the officer's agency. ~~:~~

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

~~2. A description of the vehicles involved.~~

~~3. The names and addresses of the parties involved.~~

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

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

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

(d) ~~(c)~~ Each party to the crash must ~~shall~~ provide the law enforcement officer with proof of insurance, which must ~~to~~ be included in the crash report. If a law enforcement officer submits a report on the accident, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a

noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

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

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

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

Section 4. Paragraphs (f) and (g) of subsection (4) of section 400.9905, Florida Statutes, are amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(f) A sole proprietorship, group practice, partnership, ~~or~~ corporation, or other legal entity that provides health care services by practitioners licensed under chapter 458, chapter 459, chapter 461, chapter 466, or chapter 460 and subject to the limitations of s. 460.4167 ~~physicians covered by s. 627.419~~, that is directly supervised by one or more of such physicians or physician assistants, and that is wholly owned by one or more of those physicians or physician assistants or by a physician or physician assistant or ~~and~~ the spouse, parent, child, or sibling of that physician or physician assistant. A certificate of exemption is valid only for the entity, persons, and location for which it was originally issued.

(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, which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a

licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is directly supervising the health care services ~~business activities~~ and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner who is a supervising owner 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) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b). A certificate of exemption is valid only for the entity, persons, and location for which it was originally issued.

Section 5. Subsection (6) is added to section 400.991, Florida Statutes, to read:

400.991 License requirements; background screenings; prohibitions.—

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

INSURANCE FRAUD NOTICE.—Submitting a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, when seeking an exemption from licensure as a health care clinic, or when demonstrating compliance with part X of chapter 400, Florida Statutes, is a criminal act under s. 817.234, Florida Statutes, or a fraudulent insurance act as defined in s. 626.989,

Florida Statutes, subject to investigation by the Division of Insurance Fraud, and is grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 6. Paragraph (c) of subsection (7) of section 817.234, Florida Statutes, is amended, present subsection (12) of that section is renumbered as subsection (13), and a new subsection (12) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(7) or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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

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

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

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

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

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

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

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

Section 7. This act shall take effect upon becoming a law.

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

Remove the entire title and insert:

An act relating to motor vehicle personal injury protection insurance; amending s. 627.4137, F.S.; requiring disclosures to a self-insured corporation be to be sent by certified mail; amending s. 627.736, F.S.; revising a reference to Medicare Part B payments as the schedule for insurers discretionary use when limiting reimbursement of certain medical services, supplies and care; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; authorizing the investigating officer to testify at trial or provide an affidavit concerning the content of the reports;

amending s. 400.9905, F.S; amending definition of "clinic" to include other legal entities; limiting a certificate of exemption to the location where issued; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; amending s. 817.234, F.S.; providing civil penalties for criminal acts that result in the unlawful receipt of insurance proceeds from a motor vehicle insurance contract; providing an effective date.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1237 (2011)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Civil Justice Subcommittee

Representative(s) Kriseman offered the following:

Amendment

Remove line 186 and insert:

lawyer advertising, subjects a person to possible criminal penalties and to a civil penalty of

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Civil Justice Subcommittee

Representative(s) Kriseman offered the following:

Amendment

Remove lines 260-261 and insert:

Section 10. After a finding by a court that a person has violated this act, any subsequent knowing