In the Florida Supreme Court

MRI ASSOCIATES OF TAMPA, INC., d.b.a. Park Place MRI,

Petitioner,

vs.

Fla. S. Ct. Case No. SC18-1390

STATE FARM MUTUAL AUTO. INS. CO.,

Fla. 2d DCA Case No. 2D16-4036

Respondent.

_____/

DISCRETIONARY REVIEW OF A DECISION OF THE FLORIDA SECOND DISTRICT COURT OF APPEAL

PETITIONER'S REPLY BRIEF ON THE MERITS

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STATEMENT OF THE CASE AND FACTS[1]

State Farm's introduction and statement of case and facts are inaccurate and argumentative. Instead of citing the actual page number of the record, State Farm vaguely cites to the first page of the document (AB 1), which requires the reader to sift through the entire document for record support (if any) for State Farm's statements. As a result, State Farm's answer brief is peppered with incorrect statements that have no record support.

Without record citation, State Farm erroneously states Policy Form 9810A "us[es] notice language suggested and approved by the Florida Office of Insurance Regulation ('OIR'), specifying that 'in no event will [State Farm] pay more than' the amounts in the Schedule" (AB 2), and similar misstatements to this effect are repeated throughout the answer brief (AB 5, 6, 10, 13, 14, 19-21, 24, 30-32). In reality, State Farm filed its proposed Policy Form 9810A with the OIR on February 6, 2012 (R 209:¶7, 588). The OIR published its memo with suggested election language *three months later*—on May 12, 2012 (R 208:¶6; R 266; RII 588). Policy Form 9810A could not possibly use OIR language that was not yet created. Indeed,

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[1] This reply brief uses the same defined terms and record citation format used in the amended initial brief. In addition, citations herein to Section 627.736, Florida Statutes refer to the 2012 through 2019 versions of that statute, in effect since July 1, 2012. Citations to **"AIB"** refer to the amended initial brief, to **"AB"** refer to the answer brief, and to **"ACB"** refer to amicus curiae brief filed by American Property Casualty Insurance Association, et al. (collectively, **"APCIA"**).

a redline comparison confirms there are many material differences between State Farm's policy language and the OIR's suggested language (RII 838-840). Further, although this case was decided on competing summary judgment motions (R 1163), there is *no evidence*[2] State Farm ever requested the OIR to approve its policy language for purposes of Section 627.736(5)(a)5, or that the OIR did approve it for such purposes (R 209:¶7; RII 588-589, 841-845). This is important because there are multiple different statutes governing the OIR's approval of insurance policy forms. *See, e.g.*, §§ 627.410, 627.411, and 627.4145, Fla. Stat. At least four judges have found the OIR's "approval" of State Farm's policy pertained to the "readability requirements" of Section 627.4145, instead of the purposes of 627.736(5)(a)5 (R 543, 643, 965; RII 575; *See also* RII 215, 303-304, 389, 505, 515-516, 526-527).

With respect to Park Place MRI's 19 PIP claims, State Farm erroneously contends that it "limited payment for each bill based on the Schedule" (AB 3), and that its payment for each MRI was "80% of the maximum amount allowed for MRIs in the Schedule" (AB 5). The parties' stipulation of facts confirms State Farm paid slightly more than the fixed amounts set by the schedule of maximum charges, but

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[2] The trial court entered a stipulated case management order (R 170-175), which required that the parties' motions would be decided solely on the facts in the parties' stipulation and that "no party may rely on additional facts or evidence not contained in or attached to the fact stipulation" (R 172:¶7). The parties' stipulation of facts does not demonstrate that OIR approved State Farm's policy for purposes of Section 627.736(5)(a)5. Instead, the stipulation expressly confirms the scope and purpose of the OIR's approval was a disputed issue of fact (R 208:¶6; 209:¶7).

less than Park Place MRI's billed amounts (R 209:¶10, 210:¶13, 269).

Next, without record support, State Farm attempts to quantify the co-payment (also known as "coinsurance") amount for each MRI (AB 4-5). No evidence or arguments concerning the co-payment amounts were ever presented by the parties, decided by the trial court or the Second District, or otherwise preserved for appeal. It appears State Farm is attempting to undermine *Progressive Select Ins. Co. v. Florida Hospital Medical Center*, 260 So.3d 219, 224 (Fla. 2018), which held the schedule of maximum charges does not apply to expenses the insured alone is obligated to pay and which are not recoverable as PIP benefits under the insurance policy. The PIP statute plainly states that the schedule of maximum charges does not apply to any medical expenses covered by coinsurance. *See* §627.736(5)(a)4.

Next, State Farm erroneously suggests the schedule of maximum charges is designed to pay a health care provider 160% "of the amount it would receive under Medicare" (A 5). The schedule of maximum charges only states "emergency transport and treatment" providers will be paid 160% of whatever amount Medicare would pay them. *See* §627.736(5)(a)1.a. However, all <u>other</u> types of health care providers described in the schedule of maximum charges are governed by specifically identified Medicare fee schedules, except for hospitals, which are governed by "usual and customary charges." *See* §627.736(5)(a)1.b-f. Here again, State Farm is apparently trying to have this Court unwittingly decide issues being

litigated in other PIP cases, but never raised or decided in this case and never preserved for appeal. *See, e.g., Crespo & Assocs., P.A., a.a.o. Ben Scoi v. Geico Gen. Ins. Co.,* 24 Fla. L. Weekly Supp. 721a (Fla. Hillsborough Cnty. Ct. Nov. 23, 2016) (PIP insurer underpaid for nurse practitioner services using 15% discount used by Medicare, but not authorized by schedule of maximum charges).[3]

Next, State Farm argues that in *Allstate Ins. Co. v. Orthopedic Specialists*, 212 So.3d 973, 975 (Fla. 2017), this Court rejected the notion "that an insurer's policy must completely disclaim the reasonable charge methodology to elect the schedule of maximum charges limitation" (AB 7; emph. added). Instead, *Orthopedic* rejected the argument that an insurance policy must completely disclaim the reasonable medical expense coverage mandate in order to elect the schedule of maximum charges. *Id.* at 212 So.3d at 975. *See also Id.* at 977 ("no insurer can disclaim the PIP statute's reasonable medical expenses coverage mandate"). As explained in the amended initial brief, the "mandate" cannot be disclaimed, but the insurer must elect one of two mutually exclusive methods to satisfy that mandate (AIB 1, 28-33). State Farm is erroneously conflating the "mandate" and the "method," and confused the Second District into making the same error (AIB 28-33).

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[3] State Farm argues it is allowed by Section 627.736(5)(a)3 to pay less than the minimum amount fixed by the schedule of maximum charges (AB 39). However, that interpretation renders Section 627.736(5)(a)1 and 2 superfluous and meaningless. *Scoi,* 24 Fla. L. Weekly Supp. 721a at ¶¶ 13-14. The only exception to the fee schedule amount is when the billed amount is less. § 672.736(5)(a)5.

SUMMARY OF THE ARGUMENTS

State Farm and APCIA extensively rely on factual representations that are either contrary to the undisputed facts or unsupported by any evidence at all, and on legal arguments that State Farm (as the original appellant) did not preserve for its appeal and are otherwise without merit.

ARGUMENTS[4]

THE SECOND DISTRICT ERRONEOUSLY CONCLUDED THAT THE PIP STATUTE, AS AMENDED IN 2012, PERMITS AN INSURER TO CONDUCT A FACT-DEPENDENT CALCULATION OF REASONABLE CHARGES UNDER SECTION 627.736(5)(a) WHILE ALLOWING THE INSURER TO LIMIT ITS PAYMENT BASED ON THE SCHEDULE OF MAXIMUM CHARGES UNDER SECTION 627.736(5)(a)1

(a) Introduction

In Section V.A of the answer brief, State Farm proposes to restate the question certified by the Second District (AB 13), based on the contrived accusation that the issue framed by Park Place MRI is "narrow (and misleading)" (AB 12). The issue framed by Park Place MRI precisely matches the Second District's certified question.

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[4] State Farm's answer brief does not follow the same format, point and sub-points of the amended initial brief, and instead, presents a reorganization and avoidance of the issues actually presented in that brief. "This is inappropriate." *Rolling v. State ex rel. Butterworth*, 630 So.2d 635, 636 (Fla. 1st DCA 1994). Answer briefs "should be prepared in the same manner as the initial brief, so that the issues before the Court are joined." *Dania Jai–Alai Palace, Inc. v. Sykes,* 450 So.2d 1114, 1122 (Fla.1984). To avoid confusion and to maintain continuity, this reply brief follows the same order of presentation used in the amended initial brief.

See State Farm Mut. Auto. Ins. Co. v. MRI Associates of Tampa, Inc., 252 So.3d 773, 779 (Fla. 2d DCA 2018). By order dated July 17, 2019, this Court accepted jurisdiction based on that certified question.

Moreover, State Farm's proposed restated question (AB 13) is laced with incorrect and unproven assumptions. As for the first assumption, State Farm's policy does not "quote the PIP statute's schedule of maximum charges" (AB 13). Section 627.736(5)(a)1 states that an insurer "may limit reimbursement to 80 percent of the ... schedule of maximum charges...." State Farm concedes "PIP insurers that elect to limit medical reimbursements based on the Schedule are required to pay 80% of the Schedule amounts" (AB 5). However, instead of agreeing to pay 80% of the schedule of maximum charges, State Farm's policy agrees to pay "80% of a ... *reasonable charge*, but in no event will we pay more than 80% of the ... 'schedule of maximum charges'" (R 232). From there, State Farm's "reasonable charge" term is defined as a hybrid of various elements from the fact-dependent method of Section 627.736(5)(a) and the schedule of maximum charges method of Section 627.736(5)(a)1-5, and State Farm purports to maintain unbridled discretion to "consider[] one or more" of those elements (R 220).

In the second assumption, as explained at pages 1-2 of this brief, there is no evidence the policy "uses language suggested and approved by the [OIR]" (AB 13).

In the third assumption, there is no evidence that State Farm made an "election

to use the schedule to limit reimbursements for medical expenses (pursuant to Section 627.736(5)(a)5 ...)" (A 13). Rather, the undisputed evidence shows State Farm has not made any "election." On its face, State Farm's "reasonable charge" definition adopts two different methods at the same time (R 221). The policy does not agree to limit reimbursements "to" the schedule of maximum charges as required by Section 627.736(5)(a)1, but instead, agrees to pay no more than the schedule of maximum charges (R 232). Section 627.736(5)(a)5 allows insurers to rely on the schedule of maximum changes "only" if the insurance policy has "a notice at the time of issuance or renewal" of intent to limit payments "pursuant to" the fee schedule. Here, there is no evidence State Farm provided any of the 19 insured patients such "a notice at the time of issuance or renewal" or that the policy agrees to pay anything "pursuant to" the fee schedule. Instead, State Farm unpredictably sometimes pays more, and sometimes pays less, than the minimum amounts fixed by the fee schedule (AIB 39-41). *See Nationwide Mut. Fire Ins. Co. v. AFO Imaging, Inc.*, 71 So.3d 134, 137-138 (Fla. 2d DCA 2011) (fee schedule method is utilized in computing the minimum amount payable by PIP); *Geico Indem. Co. v. Accident & Inj. Clinic, Inc.*, -- So.3d --, 2019 WL 6974264, *3 (Fla. 5th DCA Dec. 20, 2019) (Section 627.736(5)(a)1.a-f "authorizes insurers to limit reimbursement to 80% of an amount fixed through a fee schedule") (emph. added); *Id.*, at *7 (80% of the fee schedule is "the required amount an insurer must pay"). Whenever State Farm's

payment amount deviates from the "fixed" fee schedule amount, the insured patient is exposed to balance-billing liability under Section 627.736(5)(a)4.

Section 627.736(5)(a)5 also states that a "policy form approved by the [OIR] satisfies this requirement[.]" However, to comply, the policy must actually include "a notice" making an election between one method or the other. Assume a PIP insurer wants to only use the long-standing fact-dependent method of Section 627.736(5)(a), and omits any reference to the schedule of maximum charges in its insurance policy. Such a policy—even if approved by the OIR—cannot constitute "a notice" electing the fee schedules under Section 627.736(5)(a)5 (RII 304-305, 575). Further, if the OIR approves an insurance policy form, that does not prevent the judiciary from disagreeing and invalidating the policy. *Fla. Farm Bureau Cas. Ins. Co. v. State of Fla., Off. of Ins. Reg.*, 109 So.3d 860, 861 (Fla. 1st DCA 2013); *Gonzalez v. Assocs. Life Ins. Co.,* 641 So.2d 895, 896-897, n. 1 (Fla. 3d DCA 1994); *Kaufman v. Mut. Omaha Ins. Co.,* 681 So.2d 747, 749 and n. 4 (Fla. 3d DCA 1996).

State Farm's argument that the Legislature has "delegated" authority to the OIR to decide compliance (AB 10, 30) is incorrect. State agencies, such as the OIR, have no authority to interpret or enforce contracts, or adjudicate contract disputes, because such authority and jurisdiction is vested exclusively in the judiciary. *See Peck Plaza Condo. v. Div. of Fla. Land Sales & Condo., Dept. of Bus. Reg.,* 371 So.2d 152, 153-54 (Fla. 1st DCA1979); *Biltmore Constr. Co. v. Dep't of Gen. Servs.,*

363 So.2d 851, 853-854 (Fla. 1st DCA 1978); *Vincent J Fasano, Inc. v. School Bd. of Palm Beach,* 436 So.2d 201, 202 (Fla. 4th DCA 1983). Section 627.736(5)(a)5 does not state such authority has been "delegated" to the OIR, and such a delegation would violate the constitutional separation of powers doctrine by circumventing the judicial branch's exclusive jurisdiction to determine contract disputes. *See Askew v. Cross Key Waterways*, 372 So.2d 913, 924 (Fla. 1978). *See also* R 798-802.

(b) State Farm's insurance policy combines the two methods

It is true that State Farm's policy includes some language found in the PIP statute and the OIR memo. Nevertheless, State Farm's policy materially modifies that language with its unique "reasonable charge" term and definition. State Farm concedes "PIP insurers that elect to limit medical reimbursements based on the Schedule *are required* to pay 80% of the Schedule amounts" (AB 5). However, based on the "reasonable charge" definition, the policy does not agree to pay 80% of the fixed fee schedule amount, and instead, purports to give State Farm discretion to "consider[] one or more" elements of both methods. State Farm admitted that its policy "'leaves open the possibility" that it might *pay less* than the fixed fee schedule amount (R 698, 842). State Farm routinely does pay less (AIB 37), which is unlawful. *Nationwide,* 71 So.3d at 137-138. When a PIP insurer reserves the right to pay less than the fee schedule, it has not elected the fee schedule method and it exposes the insured to balance-billing liability under Section 627.736(5)(a)4.

(c) The Legislature's renumbering of Section 627.736(5)(a)1-5 in 2012 was not a substantive change and did not overturn prior appellate decisions

The Second District's renumbering theory is not mere "dicta" (AB 34); it forms the cornerstone of the court's holding that "[b]ased on the current construction of the PIP statute, we conclude that there are no longer two mutually exclusive methods...." *MRI Associates*, 252 So.3d at 778. There is no legislative history mentioning any renumbering of Section 627.736(5)(a)1-5 or any intention to combine the two methods. Thus, this renumbering was apparently accomplished under the editorial function of the Office of Legislative Services, and not by a vote of the Legislature. *See* §11.242, Fla. Stat. *See also State v. Ingleton*, 653 So.2d 443, 444–45 (Fla. 5th DCA 1995) (1982 amendment of statute's paragraph format "was not the result of any legislative enactment" and was "apparently" an "editorial" revision by the Statutory Revision Division under Section 11.242).

State Farm's so-called legislative history discussion (AB 17-18) is largely comprised of inadmissible hearsay from documents that State Farm agreed to rely on solely as "legal authority" (R 210-211:¶15), and it violates the trial court's order concerning the facts and evidence that would govern the parties' respective summary judgment motions (R 172:¶7). This is not a case about fraud or improper billing practices. It is about unlawful insurance policy provisions that purport to give State Farm unfettered discretion to pay whatever amount it deems to be a "reasonable charge" instead of the fixed amounts set by Section 627.736(5)(a)1 and 2.

(d) *Virtual III* and *Orthopedic* apply to State Farm Policy 9810A and require State Farm to elect between the two methods, without combining them

Park Place MRI stands on this section of its amended initial brief.

(e) The Second District misapprehended the distinction between the reasonable medical expenses coverage "mandate" and the fact-dependent reasonable amount "method"

Like the Second District below, State Farm and APCIA erroneously conflate the reasonable medical expenses coverage "mandate" and the fact-dependent reasonable amount "method" (AB 7, 11, 14, 21, 25; ACB 3, 13-15). They ignore that the Second District made the same mistake in *Allstate Fire & Cas. Ins. Co. v. Perez ex rel. Jeffrey Tedder, M.D., P.A.,* 111 So.3d 960, 962 (Fla. 2d DCA 2013), and that was "the very reason" this Court rephrased the certified question in *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.,* 141 So.3d 147 (Fla. 2013) ("***Virtual III***"). *See Id.,* at n. 8. State Farm and APCIA want this Court to make that same mistake.

(f) State Farm Policy 9810A is not "more clear and unambiguous" than the Allstate policy that made the proper election in *Orthopedic*

After ignoring the significance of the "reasonable charge" definition in Policy Form 9810A, State Farm relies on cases that found insurance policies issued by other PIP insurers properly elected the fee schedule method. *See S. Fla. Wellness, Inc. v. Allstate Ins. Co.*, 89 F.Supp.3d 1338 (S.D. Fla. 2015); *John S. Virga, D.C., P.A. v. Progressive Am. Ins. Co.,* 2016 WL 3866364 (S.D. Fla. 2016). However, Allstate's and Progressive's insurance policies do not include State Farm's unique "reasonable

charge" definition, which combines elements from both the fact-dependent method and the fee schedule method. Indeed, this Court held that Allstate's policy plainly "states in mandatory language that benefit payments must or will be made in accordance with" the schedule of maximum charges. *Orthopedic*, 212 So.3d at 979 (emph. added). *See also S. Fla. Wellness,* 89 F.Supp.3d at 1341 (Allstate's fee schedule provision "leaves no wiggle room"). State Farm has no such mandatory language. Instead, State Farm says it can "consider[] one or more elements" of the fact-dependent method or the fee schedule method. So, unlike Allstate's policy, State Farm's policy provides plenty of "wiggle room" to apply or reject the fee schedules.

Virga is a federal trial court order, and not a decision on the merits. That court dismissed the plaintiff's complaint for failure to state a cause of action on the grounds that a declaratory relief claim is supposedly "available only in the absence of an adequate remedy at law." *Id.*, 2016 WL 3866364 at *3. On its face, this trial court order is clearly wrong under federal law and Florida law--both of which confirm that the existence of another adequate remedy does not preclude declaratory relief. *See* Fed. R. Civ. P. 57; § 86.111, Fla. Stat.; *Maciejewski v. Holland*, 441 So.2d 703, 704 (Fla. 2d DCA 1983); *Turco v. Ironshore Ins. Co.,* 2018 WL 6181348, *1-2 (M.D. Fla. Nov. 27, 2018). The remainder of the *Virga* trial court order is purely *dicta.*

Moreover, the Progressive insurance policy in *Virga* is materially different from State Farm's policy. *Virga* explains Progressive's policy relies on a definition

for "medical benefits" that does not "ostensibly refer[] to the reasonableness, fact-based method[.]" *Virga*, 2016 WL 3866364 at *4. In contrast, paragraphs 1, 2, 3, 4, and 6 of State Farm's "reasonable charge" definition adopt elements of the fact-dependent method of Section 627.736(5)(a), while paragraphs 5 and 7 adopt elements of the fee schedule method from Section 627.736(5)(a)1 and 3. The "reasonable charge" definition begins with the statement that State Farm can "consider[] one or more" of those various elements. Thus, *Virga* does not apply.

While "no magic words" are required (AB 22), the policy must include "a notice" making "a choice" between one method "or" the other. *Virtual III,* 141 So.3d at 156-157; §627.736(5)(a)5. State Farm's policy does neither.

(g) The language of State Farm's policy is not "virtually identical" to that of Section 627.736(5)(a)1.a-f

Park Place MRI stands on this section of its amended initial brief.

(h) State Farm's inconsistent and unpredictable payments are contrary to an election of the schedule of maximum charges

Contrary to the Second District's conclusion in *MRI Associates*, 252 So.3d at 774, n.1, and contrary to State Farm's representation (AB 36), the amount actually paid by State Farm in this case is an issue that is within the scope of the pleadings, the trial court's case management order, the parties' stipulation, and the trial court's final order, which correctly concluded "State Farm is not authorized to rely on Medicare's limiting charge fee schedule" (R 1166; RII 1196-1200). Whenever State

Farm pays an amount that differs from the fixed fee schedule amount, that exposes the insured patient to balance-billing and invites litigation over whether the higher billed amount is recoverable under the fact-dependent method.

The limiting charge fee schedule is not mentioned in the PIP statute or State Farm's insurance policy. State Farm's self-serving alleged reasons for relying on the limiting charge fee schedule to pay an amount higher than the fixed fee schedule amount (AB 38) are unsupported by any evidence or by the parties' stipulation of facts, and are expressly prohibited by the trial court's case management order (R 172:¶7). Indeed, one might reasonably suspect that State Farm slightly *overpaid* all of the 19 PIP claims in this case as a tactical maneuver to portray itself in a favorable light when it cherry-picked Park Place MRI to be the sole defendant in this declaratory action, instead of naming as defendants any of the many health care providers that State Farm routinely *pays less than* the fixed fee schedule amount.

(i) The Second District's erroneous decision has significant ramifications

According to State Farm, insureds will benefit from the hybrid method because they will supposedly receive more medical services for their $10,000 of PIP benefits. This argument was rejected in *Virtual III,* 141 So.3d at 159-160 and *Geico Indem. Co. v. Virtual Imaging Servs., Inc.,* 79 So.3d 55, 58, n. 1 (Fla. 3d DCA 2011).

The argument is also wrong. State Farm's hybrid method hurts insureds by exposing them to balance-billing under Section 627.736(5)(a)4. Also, if PIP insurers

are authorized to pay less than the fixed fee schedule amount, that will reduce the array of medical providers willing to accept PIP benefits in lieu of direct payment from the patient. *See MRI Assoc. of St. Pete, a.a.o. Volpe v. Safeco Ins. Co. of Illinois*, 17 Fla. L. Weekly Supp. 686a, ¶10 (Fla. Hillsborough Cnty. Ct. 2010). If State Farm's hybrid method gives insureds more services for their $10,000 of PIP benefits, it is because State Farm has given itself an unlawful discount, at the expense of medical providers who are underpaid and the insured patients who are exposed to balance-billing. If State Farm believes its method is better than the two mutually exclusive methods, State Farm should lobby the Legislature to amend the PIP statute. Until then, State Farm must comply with the PIP statute as written.

REPLY TO APCIA'S AMICUS BRIEF

APCIA's amicus brief largely duplicates State Farm's arguments, cites to self-serving one-sided propaganda published by the insurance industry, and is otherwise without merit. The so-called "empirical data" and reports upon which APCIA relies (ACB 4-5, 8, 18-19) are inadmissible hearsay from outside of the record on appeal, and violate the trial court's case management order by attempting to rely on alleged facts not included within the parties' stipulation (R 172:¶7).

APCIA's suggestion that this Court should recede from or "clarify" *Virtual III* will call into doubt--and trigger Florida Rule of Civil Procedure 1.540(b)(5) motions to vacate--thousands of PIP decisions issued over the past six years that are based

on *Virtual III*. Also, insurance policies have been rewritten and thousands of PIP claims have been settled based on *Virtual III*. Unraveling all that makes no sense.

APCIA's contention that the two methods are not mutually exclusive is without merit. *Virtual III* expressly held that PIP insurers must make "a choice" between using the new fee schedule method "or" continuing to use the longstanding fact-dependent method. *Id.,* 141 So.3d at 157. In light of that holding, Judge Canady's dissent correctly observed that *Virtual III* is based on the premise that the two methods are "mutually exclusive." *Id.,* 141 So.3d at 160 (Canady, J., dissenting). Thereafter, in *Orthopedic,* Justice Canady, writing for the majority, followed *Virtual III* without undermining or eroding that premise. Merging the two methods together will trigger balance-billing under Section 627.736(5)(a)4, and costly "reasonable amount" litigation whenever a PIP insurer pays any amount that differs from the fixed fee schedule amount. Because this Court's recent *Florida Hospital* decision is premised upon the mutually exclusive nature of the two methods, the calculation of expenses covered by the PIP deductible will also be called into doubt. Medical bills, insurance claims, and lawsuits that have been resolved based on *Florida Hospital* will get unraveled. Surely, this cannot be the result contemplated by the Legislature.

CONCLUSION

WHEREFORE, this Court should answer the certified question in the negative, reverse the Second District's decision, and affirm the trial court's decision.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy hereof was **Electronically Filed** with the Clerk of the Court, and **Electronically Served** on the following persons on this 3rd day of JANUARY, 2020:

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CERTIFICATE OF COMPLIANCE

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