



**IN THE DISTRICT COURT OF APPEAL
FOR THE FIRST DISTRICT
STATE OF FLORIDA**

KEVIN M. MCCARTY, in his official capacity
as the Commissioner of the FLORIDA OFFICE
OF INSURANCE REGULATION,

Appellant,

vs.

Case No. 1D13-1355
L.T. No. 2013-CA-0073

ROBIN A. MYERS, D.C., et al.

Appellees.

_____ /

APPELLANT’S RESPONSE TO ORDER TO SHOW CAUSE

Appellant Kevin M. McCarty, as Commissioner of the Florida Office of Insurance Regulation (the “Office”), respectfully submits this response to the Court’s April 10, 2013 order. The Court asks the Office to show cause “why this appeal should not be dismissed for lack of jurisdiction because the order on appeal does not appear to be an appealable non-final order pursuant to Florida Rule of Appellate Procedure 9.130.”

The Office appeals the trial court’s “Order Granting In Part Motion For Temporary Injunction,” (the “Temporary Injunction,” Att. 1 to this Response).¹ Notwithstanding Rule 1.610(c)’s command that every temporary injunction “shall

¹ This Court’s Order requested that the Office attach copies of the Motion and other documents referenced in this Response.

describe in reasonable detail the act or acts restrained without reference to a pleading or another document,” the Temporary Injunction is devoid of any specificity regarding its effect. This facial defect is dispositive of the appeal, but it does not deprive this Court of jurisdiction.

INTRODUCTION AND BACKGROUND

During its 2012 session, the Florida Legislature amended the Florida Motor Vehicle No-Fault Law, which has been in place since 1971. “The No-Fault Law is a comprehensive statutory scheme, the purpose of which is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits.” *Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 961 So. 2d 328, 331-32 (Fla. 2007) (internal quotation marks omitted). The “Personal Injury Protection” provision, also known as the “PIP” provision, “is an integral part of the no-fault statutory scheme,” requiring automobile insurance policies to provide certain PIP benefits. *Id.* (citations omitted); *see also* § 627.736(1), Fla. Stat. (2012).

Faced with reports of escalating fraud and abuse among those seeking PIP benefits,² the Legislature amended PIP (the “Amendments”). Relevant to this appeal, the Amendments limited the scope of PIP benefits that insurance policies

² *See, e.g.*, Office of the Ins. Consumer Advocate, *Report on Fla. Motor Vehicle No-fault Insurance (Personal Injury Protection)* 4 (Dec. 2011), available at <http://www.myfloridacfo.com/ICA/docs/PIP%20Working%20Group%20Report%2012.14.2011.pdf>.

must provide for nonemergency medical care, and they generally eliminated benefits for massage therapy and acupuncture from PIP coverage. Ch. 2012-197, § 10, at 14, 16, Laws of Fla.

Appellees initiated the action below by filing a seven-count complaint challenging the Amendments' constitutionality.³ Shortly thereafter, Appellees filed a Motion for Temporary Injunction (the "Motion," Att. 3 to this Response), in which they asked for "a Temporary Injunction enjoining Defendants [sic⁴] from enforcing the provisions of the 2012 PIP Act." Att. 3 at 22. The trial court found portions of the Amendments inconsistent with the constitutional right of access to courts, and it granted the Motion "as to those sections of the law which require a finding of emergency medical condition as a prerequisite for payment of PIP benefits or that prohibit payment of benefits for services provided by acupuncturists, chiropractors and massage therapists." Att. 1 at 7. The Office appealed.

³ Appellees include an Acupuncture Physician, a Chiropractic Physician, two Licensed Massage Therapists, "John Doe" (purportedly on behalf of all similarly situated providers) and "Jane Doe" (purportedly on behalf of all individuals injured by motor vehicle collisions). They assert various claims under the Florida Constitution, including impairment of contracts and violations of the single-subject rule, the separation of powers, equal protection, the right to be rewarded for industry, due process, the right to work regardless of union membership, and access to courts. *See* Att. 2 (Complaint) at 1, 25-26, 27, 28, 29-30.

⁴ Kevin McCarty, in his official capacity as Commissioner of the Florida Office of Insurance Regulation, is the sole defendant. *See* Att. 2 at ¶ 33.

ARGUMENT

Because its purpose was to grant injunctive relief, the Temporary Injunction is an appealable non-final order, and this Court has jurisdiction. *See* Art. V, § 4(b)(1), Fla. Const.; Fla. R. App. P. 9.030(b)(1)(B); 9.130(a)(3)(B). But if this Court nonetheless concludes it lacks jurisdiction, its dismissal order should make clear that the dismissal follows this Court’s determination that the Temporary Injunction enjoins nothing, so that the Office is freed from the substantial harm and uncertainty that prompted this appeal.

A. THIS COURT HAS JURISDICTION BECAUSE THE TEMPORARY INJUNCTION IS AN APPEALABLE NON-FINAL ORDER.

Despite its invalidity, the Temporary Injunction falls into the category of orders that “grant, continue, modify, deny, or dissolve injunctions.” Fla. R. App. P. 9.130(a)(3)(B). Accordingly, this Court has jurisdiction.

1. The Trial Court Intended To Order Injunctive Relief.

In evaluating the jurisdictional issue, this Court should first examine the trial court’s intent. *See Gleicher v. Claims Verification Inc.*, 908 So. 2d 561, 561 (Fla. 4th DCA 2005) (dismissing appeal because trial court intended “further judicial effort before any injunction becomes effective”); *Terex Trailer Corp., v. McIlwain*, 579 So. 2d 237, 241 (Fla. 1st DCA 1991) (exercising jurisdiction over non-final order granting partial summary judgment because the Court construed order as temporary injunction); *see also Supreme Fuels Trading FZE v. Sargeant*, 689 F.3d

1244, 1246-47 (11th Cir. 2011) (Pryor, J., concurring) (“Whether the [trial] court intended to issue an injunction is the critical issue in determining whether we can entertain an interlocutory appeal . . .”).⁵

Here, the trial court clearly intended to order injunctive relief. The court styled its order “Order Granting in Part Motion for Temporary Injunction” and suggested it was “maintaining the status quo” by issuing the injunction. Att. 1 at 1. The order expressly stated that the Motion was “granted” as to certain sections of the law. *Id.* at 7. And the “granted” Motion included this specific request under the “Conclusion & Prayer for Relief”:

Wherefore, Plaintiffs most respectfully request that this Honorable Court enter a Temporary Injunction enjoining Defendants from enforcing the provisions of the 2012 PIP Act until such time as this Honorable Court may conduct a trial on the merits of Plaintiffs’ cause.

Att. 3 at 22. The Motion also warned that immediate injunctive relief was necessary because “enforcement” of the new law was “scheduled to begin on January 1, 2013”—two weeks before Appellees filed their Motion. *Id.*

Critically, the Motion sought no relief other than a temporary injunction, and the order granted no relief other than a temporary injunction. This case is therefore unlike *City of Panama City v. Andina, Inc.*, 63 So. 3d 908 (Fla. 1st DCA 2011), an appeal this Court dismissed. There, appellant argued that a partial summary

⁵ Like this Court, federal appeals courts have jurisdiction over interlocutory appeals of orders granting injunctions. 28 U.S.C. § 1292(a)(1).

judgment order was appealable because the trial court granted summary judgment as to counts that sought injunctive relief. *Id.* at 908. This Court disagreed, concluding that “[t]he order does no more than grant a motion for partial summary judgment”: it did not “direct the City to take, or refrain from taking, any action.” *Id.* That order’s purpose, therefore, was simply to grant summary judgment. The sole purpose of the Temporary Injunction here, on the other hand, was to grant injunctive relief.

This case is likewise different from *Gleicher v. Claims Verification Inc.*, in which the order was not appealable because it “contemplate[d] further judicial effort before any injunction becomes effective,” meaning the trial court had not yet intended to enjoin anything. 908 So. 2d at 561. But the Temporary Injunction here contemplated no further judicial effort and did not delay its effectiveness. Indeed, the trial court found that Plaintiffs would suffer irreparable harm if the injunction did not issue. Att. 1 at 2. And after the Office initiated this appeal and invoked the Rule 9.310(b)(2) automatic stay, the trial court heard Plaintiffs’ Emergency Motion to Vacate Defendants’ Notice of Automatic Stay. *See* Att. 4 (notice of hearing). The trial court’s clear intent, therefore, was to effect immediate injunctive relief.

2. The Temporary Injunction Is Facially Invalid.

In its initial brief, the Office will detail the assorted errors permeating the Temporary Injunction. Regarding this jurisdictional inquiry, however, one defect predominates: the Temporary Injunction provided no specificity as to what the Office must do (or not do) to obey the order.

“An order granting a temporary injunction must strictly comply with Florida Rule of Civil Procedure 1.610.” *Randolph v. Antioch Farms Feed & Grain Corp.*, 903 So. 2d 384, 385 (Fla. 2d DCA 2005). And that Rule provides that all injunction orders “shall describe in reasonable detail the act or acts restrained without reference to a pleading or another document.” Fla. R. Civ. P. 1.610(c); *accord F. V. Inves., N. V. v. Sicma Corp.*, 415 So. 2d 755, 755 (Fla. 3d DCA 1982) (injunction invalid if “the acts enjoined by the injunction are not specified with such reasonable definiteness and certainty that the defendants bound by the decree would know what they must refrain from doing without the matter being left to speculation and conjecture.”).

Because the Temporary Injunction’s command is not clear on its face, one must turn to the Motion that the order granted. But even the Motion—to the extent it was incorporated into the Order—was ambiguous about the precise relief sought. The Motion sought an injunction prohibiting “enforcement” of the Act, but the portions to which the Motion was granted—“those sections of the law which

require a finding of emergency medical condition as a prerequisite for payment of PIP benefits or that prohibit payment of benefits for services provided by acupuncturists, chiropractors and massage therapists”—are not provisions the Office directly enforces. Instead, those provisions specify the levels of coverage “an insurance policy complying with the security requirements of § 627.733 must provide.” § 627.736(1), Fla. Stat. Section 627.733, in turn, requires that “[e]very owner or registrant of a motor vehicle . . . shall maintain security” as required by PIP, which requirement is satisfied by carrying an insurance policy providing all required PIP coverage. So the thrust of the “enjoined” provisions is to establish the scope of insurance coverage motorists must carry.

That is not to say the Office has no authority at all relating to these provisions. The Office must, for example, approve insurers’ contract forms, which must comply with law. *See* § 627.410, Fla. Stat. And the Office has authority to impose penalties on insurers not complying with law. *See, e.g., id.* § 624.307. But it is hopelessly unclear exactly how the Office would comply with an order to stop “enforcing” the challenged provisions. Must the Office withdraw existing form approvals? Must it revoke licenses? Must it revoke approvals? The Temporary Injunction offers no direction, even though “[t]he one against whom [an injunction] is directed should not be left in doubt about what he is to do.” *Pizio v.*

Babcock, 76 So. 2d 654, 654 (Fla. 1954); accord *Moore v. City Dry Cleaners*, 41 So. 2d 865, 871 (Fla. 1949).

3. **The Temporary Injunction’s Invalidity Does Not Deprive This Court of Jurisdiction.**

When an injunction fails to specify the enjoined conduct, the proper remedy is to reverse the order—not dismiss the appeal. Therefore, in *Seminole County School Board v. Downey*, 59 So. 3d 1156 (5th DCA 2011), the Court reversed a temporary injunction order because “[t]here [was] no effort to describe the acts being restrained.” 59 So. 3d 1156, 1160 (5th DCA 2011). Similarly, in *Angelino v. Santa Barbara Enterprises, LLC*, the Court reversed because the temporary injunction “fail[ed] to designate with sufficient particularity the acts or things enjoined against.” 2 So. 3d 1100, 1104 (Fla. 3d DCA 2009); see also *Moore*, 41 So. 2d at 865, 871 (invalidating portion of injunction “because of the indefinite and uncertain language in which it is framed”); *F. V. Inves.*, 415 So. 2d at 755 (reversing temporary injunction because the acts enjoined were “not specified with such reasonable definiteness and certainty that the defendants bound by the decree would know what they must refrain from doing”). As these cases demonstrate, the trial court’s error warrants reversal but does not deprive this Court of appellate jurisdiction.

Federal courts similarly have recognized that a facially invalid injunction still confers appellate jurisdiction. See *Schmidt v. Lessard*, 414 U.S. 473, 477

(1974) (“[A]lthough the order below is sufficient to invoke our appellate jurisdiction, it plainly does not satisfy the important requirements of Rule 65(d).”); *Supreme Fuels Trading FZE*, 689 F.3d at 1247 (Pryor, J., concurring) (“When a [trial] court denominates its order as an injunction, we have jurisdiction to entertain an appeal from that order even if the [trial] court fails to comply with the requirements of [the Rule governing injunctions].”); *Hatten–Gonzales v. Hyde*, 579 F.3d 1159, 1169 (10th Cir. 2009) (concluding order “serves as an injunction for jurisdictional purposes, even if it fails to comply with Rule 65(d)” because “the [trial] court plainly intended to provide plaintiffs injunctive relief and entered an order attempting to do so”).

This Court has jurisdiction, so it should discharge the show-cause order.

B. IF THIS COURT DISMISSES THE APPEAL, ITS ORDER SHOULD CLARIFY THAT THE TEMPORARY INJUNCTION HAS NO EFFECT.

The Office appealed because of the great uncertainty surrounding the Temporary Injunction’s scope and effect. Appellees seem to believe insurers must modify their existing insurance policies to provide coverage beyond what the statute requires. Their counsel said at the hearing on Appellees’ Emergency Motion to Vacate the Automatic Stay:

I don’t know the extent of the effort that would have to be taken by the insurance companies to have to correct this, but having studied how they adopted and implemented the changes that were brought about by the adoption of the challenged legislation, it seems to me relatively easy to send out a memo, an e-mail to the people and say,

“Look, here are some very, very minor changes. There is no longer the requirement that people seeking coverage have to establish that emergency medical condition, and there’s no longer a prohibition against licensed massage therapists and acupuncturists who provide services that they have historically done prior to the adoption of this challenge[d] legislation.”

(Att. 5 (Trans.) at 11-12.) But the Temporary Injunction did not order insurers—or any other non-parties—to do anything. Nor did it order motorists, who are required to carry PIP coverage or provide other security, to enhance their insurance coverage or otherwise respond to the order. Of course, the trial court was limited in the relief it *could* grant, *see, e.g., Sheoah Highlands, Inc. v. Daugherty*, 837 So. 2d 579, 583 (Fla. 5th DCA 2003) (“A court is without jurisdiction to issue an injunction which would interfere with the rights of those who are not parties to the action.”), but this just makes it all the more difficult to discern what the trial court actually intended to effect.

And the substantial uncertainty does not just burden the Office—it extends to Florida’s entire insurance market. In moving for leave to file an amicus brief, a coalition of insurers reported:

This ruling by the circuit court has a significant impact on [Movants’] members. While the order purportedly enjoins FLOIR enforcement of certain of the 2012 Amendments, the 2012 Amendments remain duly enacted, valid law. Among other things, the circuit court’s ruling creates substantial uncertainty among the members as to whether or not they should comply with valid law and their FLOIR-approved contracts with insureds which incorporate the provisions of the 2012 Amendments. There are potentially serious repercussions to the

members if they comply with the 2012 Amendments and potentially serious repercussions if they do not comply.

(Motion of Personal Ins. Fed. of Fla. & the Nat'l Ass'n of Mut. Ins. Cos., Apr. 9, 2013, at 3.) Insurance consumers, too, are left to wonder whether the Temporary Injunction changes their existing coverage. Relief from the Temporary Injunction is necessary to address the substantial uncertainty the order created.

Accordingly, *if* the Court dismisses the appeal based on a conclusion that the Temporary Injunction did nothing, the Court should make clear in its dismissal order that the Temporary Injunction imposes no obligations on the Office—or anyone else—and that it does nothing to alter the pre-injunction status quo. Otherwise, the Office will be left in the intolerable position of facing an imprecise injunction without any ability to seek review.

WHEREFORE, the Office respectfully asks that this Court:

1. Discharge the show-cause order;
2. Allow the Office fourteen days after discharge to file its initial brief;
3. Ensure that—if the Court dismisses the appeal—its dismissal order specifies that the Temporary Injunction requires no action from the Office or others and does not alter the pre-injunction status quo; and
4. Grant any further relief the Court finds appropriate.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished by
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ATTACHMENT 1

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IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, FLORIDA

ROBIN A. MYERS, D.C., et al,

CASE NO: 2013 CA 73

Plaintiffs,

vs.

KEVIN M. McCARTY, in his Official
Capacity as the Commissioner of The
Florida Office of Insurance
Regulation,

Defendant.

ORDER GRANTING IN PART MOTION FOR TEMPORARY INJUNCTION

THIS CASE is before me on the Plaintiffs' Motion for Temporary Injunction. The Plaintiffs are chiropractic physicians, massage therapists and acupuncturists who have filed a complaint for declaratory and injunctive relief, challenging the constitutionality of Chapter 2012-197, Laws of Florida (2012 PIP Act or "the Act.") A hearing was held on the Plaintiffs' motion for temporary injunction on February 1, 2013. I have considered the evidence, the written and oral arguments of counsel and the authorities cited. For the reasons set forth below, I find that the motion should be granted in part because the Act violates Article I, Section 21 of the Florida Constitution (Access to Courts).

I first address the standing issue raised by the Defendant. Because the Plaintiffs are seeking to enforce a right vested in members of the public at large, they must allege and establish some special injury different in kind from the injury suffered by members of the public. The complaint alleges, and the evidence showed, that the Plaintiffs, as health care providers for

automobile accident victims, derive a substantial percentage of their income through PIP insurance payments. Because the Act, as revised, prohibits or severely limits future payments from PIP insurance for such treatment, they have a sufficient interest in the outcome of the case, as well as an injury that is distinct from that of the public at large. I thus find that Plaintiffs have standing and will address the merits of their motion for temporary injunction.

In order to obtain a temporary injunction, the Plaintiffs have the burden of establishing that they will suffer irreparable harm if the injunction is not entered, that they have no adequate legal remedy available, that there is a substantial likelihood that they will succeed on the merits and that the injunction is in the public interest. It seems clear to me that the Plaintiffs have alleged and proven irreparable harm and inadequate legal remedy. Moreover, there appears to be no adverse consequence to the public interest in maintaining the status quo if the injunction is issued. The real question is whether the Plaintiffs have shown a substantial likelihood of success on the merits.

In that regard, the Plaintiffs have challenged the Act on several grounds which I summarize as follows: (1) the Act violates their procedural and substantive due process rights by taking away their ability to contract and to earn a living through their chosen profession; (2) the Act violates substantive due process because it is not rationally related to a legitimate public policy or objective; (3) The Act violates the single subject rule and the separation of powers; and (4) the Act violates the right of people to have access to the courts to seek redress for their injuries. I find that the Plaintiffs have met their burden only as to this latter theory.

The common law, on which our legal system is founded, is based upon the interdependent concepts of individual liberty and personal responsibility. While each person is free to chose

what course of action is best for him, he is expected to conduct himself in such a manner so as not to cause injury to the person or property of another. And if he does cause such injury, the law holds him responsible to the injured party for the resulting loss, injury or damage. The fundamental right to seek redress for injuries received at the hands of another is a cornerstone of our legal system. This principle is embedded in our state constitution in Article I, Section 21, which provides in part:

"The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay."

These libertarian principles are also the underpinnings of our historic, free market economic system with its reverence for individual property rights. After all, the right to bring a claim against another can be a valuable property right. And, in such a system, one is free to take steps to protect oneself against the financial calamities which may be caused by the actions of another, by an unavoidable accident, or by an act of God. Hence the business of insurance.

Over the years, for various reasons or purposes, our representatives in state and federal government have tinkered with these fundamental principles and overridden or altered the common law which embodies them. They have, in some areas, replaced a pure free market approach with a government controlled system in order to address a perceived problem. The "No-Fault law" passed by the Florida Legislature in 1971, and as subsequently revised, is just one example of this experiment with socialism¹ and the trend away from those libertarian principles of individual liberty and personal responsibility.

¹ I use the popular, if somewhat inaccurate meaning -- any law that intrudes significantly into the free market arena with government mandates, e.g., socialized medicine.

The 1971 legislation took away or severely limited the right of a person injured in a Motor vehicle accident to seek redress in court for injuries wrongfully caused by another, relieving the wrongdoer of responsibility for his conduct, and granting him immunity from civil liability. In place of this valuable right, the Legislature instituted a "no-fault" system in which everyone who owned or operated a motor vehicle was required to purchase insurance to cover medical and other expenses.

This clear impingement upon the rights set forth in Article I, Section 21, quoted above, was rationalized by asserting that the legislation was providing a "reasonable alternative" to the common law tort recovery system. Proponents argued that the tradeoff was a "good deal" because it would provide speedy payment of medical costs, lost wages, etc. of any accident victim, regardless of fault, and would avoid the alleged uncertainties and inequalities of the tort system. In theory, this would in turn lessen court congestion and delays, reduce automobile insurance premiums, and reduce the possibility that economic calamity might overwhelm accident victims and force them to accept unduly small settlements of their claims.

When the new legislation was challenged in court, the Florida Supreme Court accepted this argument, holding in Lasky v. State Farm Insurance Co., 296 So.2d 9 (Fla. 1974), that the new legislation offered a "reasonable alternative" to the right to sue. The Court noted:

"Protections are afforded the accident victim by this Act in the speedy payment by his own insurer of medical costs, lost wages, etc., while foregoing the right to recover in tort for these same benefits and (in a limited category of cases) the right to recover for intangible damages to the extent covered by the required insurance...; furthermore, the accident victim is assured of some recovery even where he Himself is at fault. In exchange for his former right to damages for pain and suffering in the limited category of cases where such items are preempted by the act, he receives not only a prompt recovery of his major, salient out-of-pocket losses -- even where he is at fault -- but also an immunity for being held liable for the pain and suffering of the other parties to the accident if they should fall within this limited class where such items are not

recoverable.

296 So.2d @ 14.

The Court contrasted this trade-off with the provision that denied the right of recovery for property loss under \$550.00 which the court disapproved in the case of Kluger v. White, 281 So.2d 1 (Fla. 1973). The court held in Kluger that there was no reasonable alternative provided to the traditional tort action. The injured party simply was denied any right of recovery or access to the courts. But as for PIP, the court in Lasky held that while injured persons couldn't go into court for a redress of their injuries, the legislation was really a better deal for them, so it was a "reasonable alternative." The court accordingly upheld the legislation as constitutionally valid.

In the forty-odd years since its passage, the Legislature has periodically revised the no-fault law. Some revisions have fostered other constitutional challenges, including the case of Chapman v. Dillion, 415 So.2d 12 (Fla. 1982). Along the way, that case was reviewed by the Fifth District Court of Appeal, which held the revised law to be unconstitutional. The DCA opined that changes made to the law since the Lasky decision had altered the no-fault law such that it was no longer a reasonable alternative to the right to redress injury in court. Specifically, the court noted that the restrictions on recovery of pain and suffering still remained but that the new legislation lowered the PIP benefits and raised the permissible deductible.² The Supreme Court disagreed with the District Court of Appeal and concluded that the no-fault law was still a reasonable alternative. The Court reasoned that in spite of the change in coverage and deductible,

²When Lasky was decided, PIP coverage was 100% of medical expenses and 80% of loss income. This had since been reduced to 80% of medical expenses and 60% of loss income. The maximum deductible when Lasky was decided was \$1,000 but had been subsequently changed to allow up to an \$8,000.00 deductible.

many motorists would have other insurance to pick up the slack, so that the major and salient economic losses were still covered. The Court also noted that the policy limits had been increased from \$5,000 to \$10,000.

The Court gave no bright line test or guidelines to indicate what changes in the law might prompt them to find that it was no longer a reasonable alternative to the right guaranteed in Article I, Section 21 of the State Constitution, but I note that Justice Sunberg in his concurring and dissenting opinion felt that the legislation as then enacted was "perilously close to the 'outer limits of constitutional tolerance'". 415 So.2d @ 18.

The question raised in this case by the Plaintiffs' complaint is whether the revised no-fault law passes beyond these "outer limits of constitutional tolerance." I conclude that it does. The law still has the limitations or restrictions for recovery for pain and suffering lamented in Chapman by the District Court of Appeal but rationalized away by the Supreme Court. The percentage of recovery of medical expenses is still 80% and 60% for lost income. The policy limits are still \$10,000. The legislation, however, now additionally severely limits what can be recovered under that policy, i.e., what is specifically excluded. Under the new law, an injured party who does not receive initial services or care within 14 days of an accident, is not covered. If you do seek medical care within that time frame, but it is determined that you did not have "an emergency medical condition", your recovery under the policy is limited to \$2,500. And, regardless of whether such services are deemed reasonable and necessary for care and treatment, and regardless of who may have referred an injured person, he cannot be covered under PIP for medical benefits provided by a licensed massage therapist or licensed acupuncturist.

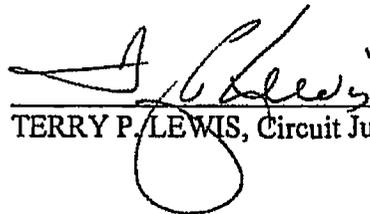
Is the no-fault law still a good deal? Is it still a reasonable alternative to the rights

guaranteed to citizens under Article I, Section 21 of the Florida State Constitution? The answer to those questions is probably, like beauty, in the eye of the beholder, and reasonable people may disagree. From my perspective, however, the revisions to the law make it no longer the "reasonable alternative" that the Supreme Court found it to be in Lasky and Chapman.

Accordingly, it is ORDERED AND ADJUDGED as follows:

The Plaintiffs' motion is granted as to those sections of the law which require a finding of emergency medical condition as a prerequisite for payment of PIP benefits or that prohibit payment of benefits for services provided by acupuncturists, chiropractors and massage therapists. In all other respects, the motion is denied.

DONE AND ORDERED in Chambers at Tallahassee, Leon County, Florida, this 15th day of March, 2013.


TERRY P. LEWIS, Circuit Judge

Copies to:

C. Timothy Gray, Esquire
Luke Lirot, Esquire

ATTACHMENT 2

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, STATE OF FLORIDA
CIVIL DIVISION

ROBIN A. MYERS, A.P., an individual person
and Acupuncture Physician, GREGORY S.
ZWIRN, D.C., an individual person and
Chiropractic Physician, SHERRY L. SMITH, L.M.T.,
an individual person and Licensed Massage Therapist,
CARRIE C. DAMASKA, L.M.T., an individual
person and Licensed Massage Therapist, "John Doe,"
on behalf of all similarly situated health care providers,
and "Jane Doe," on behalf of all those individuals
injured by motor vehicle collisions,

Plaintiffs,

v.

KEVIN N. McCARTY, in his Official Capacity as
Commissioner of the Florida Office of Insurance
Regulation,

Defendant.

C-01
BOB INZER
CLERK CIRCUIT COURT
LEON COUNTY, FLORIDA

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FILED

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Case: 2013 CA000073

Division: _____

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Through undersigned counsel and pursuant to the Florida Statutes and the Florida Rules of Civil Procedure, Plaintiffs file this Complaint against Defendant, acting in his Official Capacity as Commissioner of the Florida Office of Insurance Regulation, and respectfully request that this Court provide Plaintiffs with injunctive relief because the 2012 PIP Act violates multiple provisions of the Constitution of the State of Florida including the single subject rule, and because the 2012 PIP Act violates the Plaintiffs' constitutional rights of equal protection, due process and access to the courts. This is an action for declaratory and injunctive relief challenging the constitutionality of the 2012 PIP Act because it adversely affects each individual

Plaintiff. This action seeks, through preliminary and permanent injunction, to prevent the irreparable harm and other damages resulting from the dramatic limitations and deprivations that the 2012 PIP Act will cause both to Florida's healthcare providers and healthcare consumers.

Preliminary Statement, Jurisdiction, Venue, & Background

1. This is an action for declaratory and injunctive relief challenging the constitutionality of the 2012 PIP Act.
2. The amount in controversy for each individual Plaintiff exceeds \$15,000.00 (fifteen thousand dollars) exclusive of interest, costs, and fees.
3. This is an action for temporary and permanent injunctive relief and for declaratory and related relief. Jurisdiction is proper in this Court pursuant to:
 - a. Chapter 86 *et. seq.*, Florida Statutes, to enter declaratory judgments related to controversies of monetary sums greater than \$15,000.00 (fifteen thousand dollars)
 - b. Rule 1.610, Fla. R. Civ. Pro., and §26.012(3), Fla. Stat., this Court is authorized to enter injunctions and provide for injunctive relief;
 - c. Article I, §§ 2, 4, 6, 9, 10, 12, 21, 23, and Article X §6 of the Constitution of the State of Florida.
4. An actual and existing controversy exists between the Plaintiffs and the Defendant relative to their respective rights and duties as set forth herein.
5. Plaintiffs began losing business and suffering economic damages and non-economic damages in the form of good will and healthcare provider-patient relationships after the 2012 PIP Act was enacted.
6. There exist a clear, present, actual, substantial, and bona-fide justiciable controversy between the Parties.

7. Plaintiffs are presently experiencing irreparable harm(s) suffered by their elimination or dramatic restriction from being able to provide healthcare to those injured as a result of motor vehicle collisions.
8. Plaintiffs possess no adequate remedy at law. No amount of monetary damages may adequately compensate Plaintiffs for the irreparable harm they are already suffering including, but not limited to, the deprivation of their state constitutional rights.
9. Because the public interest will best be served by the maintenance of the status quo, this Court should grant injunctive relief and prevent enforcement of the 2012 PIP Act.
10. All conditions precedent to the institution and maintenance of this cause of action have occurred, will have been performed, or would be futile as any type of meaningful remedy for the irreparable harm identified herein.
11. The acts, practices, and jurisdiction of the Defendant, Office of Insurance Regulation, are being performed under color of state law and therefore constitute state action within the meaning of that concept.
12. Venue is proper in Leon County, the seat of the State Government of Florida, where Plaintiffs seek relief from the States' impermissible encroachment upon their constitutionally protected rights. *State ex rel. Florida Dry Cleaning & Laundry Board v. Atkinson*, 188 So. 834 (Fla. 1938), *Henderson v. Gay*, 49 So. 2d 325 (Fla. 1950).
13. The 2012 PIP Act is invalid because:
 - a. It violates the "single subject rule" required by the Florida Constitution;
 - b. It contains a variety of restrictions and limitations that the separation of powers doctrine;

- c. In the absence of either a compelling governmental interest or rational basis, it violates due process of law;
- d. It constitutes an improper taking where, once granted, professional licensure becomes a vested property right;
- e. It violates equal protection, also in the absence of a compelling governmental interest or rational basis;
- f. It is based on unsupported, unpublished statistical assumptions that were not the product of proper research methodology;
- g. It unduly limits the rights of both medical professionals and consumers;
- h. It totally voids the sufficient alternative relied upon by the courts to allow the original no-fault PIP insurance scheme to limit Floridian's access to the courts;

14. On May 4, 2012 Governor Scott approved Florida Statute Chapter 2012-197, a committee substitute for committee substitute for House Bill 119: Motor Vehicle Personal Injury Protection Insurance (2012 PIP Act).¹ [Plaintiffs' Exhibit A: Text of Chapter 2012-197].

15. Although some provisions of the 2012 PIP Act became active on July 1, 2012, the majority of the provisions leading to this action for declaratory and injunctive relief became active on January 1, 2013.

16. As noted below, the 2012 PIP Act amends ten (10) distinct sections of the Florida Statutes and creates two (2) new sections of the Florida Statutes spread across four (4) separate Titles including those for Motor Vehicles, Public Health, Insurance, and Crimes.

17. Similar to health insurance's function as a third party payor, PIP insurance is a no-fault scheme of third party payment for physical injuries sustained as a result of a motor

¹ <http://www.flsenate.gov/Session/Bill/2012/0119>, last accessed January 2, 2013.

vehicle collision. Importantly, other third party health insurance payors limit or exclude injuries from motor vehicle collisions specifically because of PIP insurance.

18. Plaintiffs seek immediate injunctive relief to prevent and enjoin Defendant, and any other “state actor” from enforcing the challenged provisions of the 2012 PIP Act because such enforcement will cause irreparable harm to Plaintiffs for which there is not adequate legal remedy.

19. Without any evidence or suggestion of fraud prevention, in the absence of any peer-reviewed, published medical literature contesting the validity or benefit of treatment by Acupuncture Physicians, Licensed Massage Therapists, and Chiropractic Physicians, and certainly without adequately informing their insureds, the 2012 PIP Act:

- a. Absolutely prohibits all Florida Licensed Acupuncture Physicians such as Plaintiffs MYERS and JOHN DOE from evaluating or treating any person covered by PIP insurance;
- b. Absolutely prohibits all Florida Licensed Massage Therapists such as Plaintiffs SMITH, DAMASKA, and JOHN DOE from treating any person covered by PIP insurance;
- c. Severely limits² all Florida Licensed Chiropractic Physicians such as Plaintiffs ZWIRN and JOHN DOE from treating any person covered by PIP insurance;

² Chiropractors may not, according to the 2012 PIP Act determine whether or not there exists an emergency medical condition, although M.D.s, D.O.s, and D.D.S.s may, thus those patients having already purchased \$10,000.00 (ten thousand dollars) in PIP insurance initially seeking Chiropractic care will be limited to only \$2,500.00 (two thousand dollars) in covered benefits. Further the 2012 PIP Act limits Chiropractic care to that allowed pursuant to the United States Centers for Medicare and Medicaid Services – thus Chiropractors will only be allowed to provide for spinal manipulations over a limited course and will no longer be allowed to employ adjuvant care with other proven, beneficial modalities

20. Plaintiffs file this action because, while Plaintiffs may continue to provide the exact same evaluation and treatment for patients with conditions that are the same but not caused by a motor vehicle collisions, the 2012 PIP Act absolutely prohibits all Florida Licensed Acupuncture Physicians and all Florida Licensed Massage Therapists from providing any medical evaluation or treatment to patients injured as a result of a motor vehicle collision, and only to those injured in this way.
21. The 2012 PIP Act severely limits all Chiropractic Physicians from providing appropriate medical evaluation and treatment only to patients injured as a result of a motor vehicle collision, and, although *all* Florida's citizens must purchase \$10,000.00 (ten thousand dollars) in PIP insurance, the 2012 PIP Act limits the coverage provided to Florida's citizens by providing *no coverage* if a citizen seeks care over 14 (fourteen) days after an accident, and only providing \$2,500.00 (two thousand five hundred dollars) in coverage *if* the citizen is not diagnosed with an "emergency medical condition" (a term undefined in the legislation) by a medical doctor (M.D.), osteopathic doctor (D.O.), or a dentist (D.D.S.).
22. Essentially, although Plaintiffs may continue to evaluate and treat Florida's citizens injured as a result of any other trauma, fall, boating accident, or other personal injury, the 2012 PIP Act either prohibits or severely limits Plaintiffs from providing the exact same evaluation and treatment for injuries sustained as a result of a motor vehicle collision.

Parties

Plaintiffs

23. Plaintiff, ROBIN ANDREW MYERS, A.P., is a Licensed Acupuncture Physician possessing a valid, active Acupuncture Physician's License issued by the Florida

Division of Medical Quality Assurance, under the auspices of the Florida Department of Health, and whose ability to provide medical evaluation and treatment to his patients is prohibited by the 2102 PIP Act. Dr. Myers' practice is located in Hillsborough County, Florida. Among his patients, Dr. Myers routinely evaluates and treats patients injured as a result of traumatic injuries, including motor vehicle collisions. Patients injured as a result of motor vehicle collisions constitute a substantially large part of Dr. Myers' business, good will, professional relationships, and income. [Plaintiffs' Exhibit B]

24. Plaintiff, GREGORY S. ZWIRN, D.C., is a Licensed Chiropractic Physician possessing a valid, active Chiropractic Physician's License issued by the Florida Division of Medical Quality Assurance, under the auspices of the Florida Department of Health, and whose ability to provide medical evaluation and treatment to his patients is severely limited and restricted by the 2102 PIP Act. Dr. Zwirn's practice is located in Hillsborough County, Florida. Among his patients, Dr. Zwirn routinely evaluates and treats patients injured as a result of traumatic injuries, including motor vehicle collisions. Patients injured as a result of motor vehicle collisions constitute a substantially large part of Dr. Zwirn's business, good will, professional relationships, and income. [Plaintiffs' Exhibit C].

25. Plaintiff, SHERRY SMITH, L.M.T., is a Licensed Massage Therapist possessing a valid, active Licensed Massage Therapist License issued by the Florida Division of Medical Quality Assurance, under the auspices of the Florida Department of Health, and whose ability to provide medical treatment to her patients is prohibited by the 2102 PIP Act. LMT Smith's practice is located in Sarasota County, Florida. Among her patients, LMT Smith routinely evaluates and treats patients injured as a result of traumatic injuries, including motor vehicle collisions. Patients injured as a result of motor vehicle collisions

constitute a substantially large part of LMT Smith's business, good will, professional relationships, and income. [Plaintiffs' Exhibit D]

26. Plaintiff, CARRIE C. DAMASKA, L.M.T., is a Licensed Massage Therapist possessing a valid, active Licensed Massage Therapist License issued by the Florida Division of Medical Quality Assurance, under the auspices of the Florida Department of Health, and whose ability to provide medical treatment to her patients is prohibited by the 2102 PIP Act. LMT Smith's practice is located in Sarasota County, Florida. Among her patients, LMT Smith routinely evaluates and treats patients injured as a result of traumatic injuries, including motor vehicle collisions. Patients injured as a result of motor vehicle collisions constitute a substantially large part of LMT Smith's business, good will, professional relationships, and income. [Plaintiffs' Exhibit E]

27. Plaintiff "JOHN DOE," represents all similarly situated citizens of Florida that are actively licensed healthcare providers licensed by Florida pursuant to the Florida Statutes, and/or own businesses providing healthcare services in Florida, and/or provide healthcare services to patients injured as a result of motor vehicle collisions in Florida.

28. Plaintiff "JANE DOE," represents all those citizens of Florida that are, were, or will be injured as a result of a motor vehicle collision that were also required to purchase \$10,000.00 (ten thousand dollars) of PIP insurance coverage but may actually only receive no or \$2,500.00 (two thousand five hundred dollars) in benefits.

29. Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA, and JOHN DOE all possess and provide healthcare related businesses and clinics that are engaged in providing healthcare services to Florida's citizens, including those citizens injured as a result of a motor vehicle collision. Each of these Plaintiffs possesses a professional license, issued by the

State of Florida. All of these Plaintiffs also possess any other necessary State or local licensure or approval necessary for the operation of their healthcare practice. Each of these professional licenses provides each Plaintiff with a cognizable property right and an interest in such property.

30. Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA, and JOHN DOE all derive significant income from reimbursement for healthcare services provided to their clients related to motor vehicle accidents. Each of these Plaintiffs possesses a viable, going business concern including good will, business good will, healthcare provider –healthcare consumer relationships, and other intangible properties.

31. Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA, and JOHN DOE's ongoing business concerns benefit the State by payment of fees and taxes.

32. Plaintiff JANE DOE possesses both a contract right to and a property right in PIP insurance by purchasing \$10,000.00 (ten thousand dollars) worth of PIP insurance coverage – coverage required by the State of Florida and purchased from an insurance carrier. The State may not, retroactively, either interfere with contract or improperly take Plaintiff JANE DOE's lawfully purchased PIP insurance.

Defendant

33. Defendant, KEVIN M. McCarty, is named in his Official Capacity as Commissioner of the Florida Office of Insurance Regulation, the Florida Agency with the authority and responsibility to enforce Florida's insurance regulations, including, but not limited to, the applicable provisions of the PIP Act.

34. The acts, practices, and jurisdiction of the Defendant McCARTY as director of the Florida Office of Insurance Regulation, are being performed under color of state law and therefore constitute state action within the meaning of that concept.

General Allegations and Brief History of Florida PIP, No-Fault, and the 2012 PIP Act

35. In an effort to swiftly and efficiently provide medical insurance coverage to persons injured as a result of motor vehicle collisions, in 1971 Florida adopted a no-fault system to provide this coverage called Personal Injury Protection (PIP) insurance.

36. As a result, possession of a minimum of \$10,000.00 (ten thousand dollars) of PIP insurance coverage is required of all Floridians desiring to own or register a motor vehicle operating within Florida. See Fla. Stat. §627.733 (2012).

37. Further, the Florida Statutes require that all automobile insurance policies include \$10,000.00 (ten thousand dollars) in medical and disability benefits as personal injury protection for: the named insured, relatives residing in the same household, persons operating the motor vehicle, passengers in the motor vehicle, and other persons suffering a bodily injury while not an occupant of the motor vehicle. See Fla. Stat. §627.736 (2012).

38. However after its enactment, PIP insurance was challenged because it limited Floridian's access to the courts. *Lasky, infra*, upheld the constitutionality of PIP insurance because the original PIP insurance framework provided swift and unfettered access to sufficient medical treatment for automobile related injuries that constituted a sufficient alternative to traditional tort actions and would also reduce automobile related lawsuits and provide payment for reasonable and necessary medical expenses related to motor vehicle collisions. *Lasky v. State Farm Insurance*, 296 So. 2d 9 (Fla. 1974).

39. *Lasky* and its progeny, relied upon each Floridian's unfettered access to sufficient medical treatment as a reasonable and sufficient alternative to such Floridian's access to the court. Because, the 2012 PIP Act dramatically restricts each Floridian's access to sufficient medical treatment, the 2012 PIP Act voids the Court's previous holdings in *Lasky*, and improperly limits Floridian's access to the courts. *Id.*

40. Before the 2012 PIP Act, Chiropractic Physicians were able to provide medical evaluation and treatment for those injured as a result of motor vehicle collisions and were able to serve as medical directors of clinics providing such services. Fla. Stat. §627.736 **Required personal injury protection benefits; exclusions; priority; claims.**, read in part (emphasis added):

- (a) *Medical Benefits.* – Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services. However, the medical benefits shall provide reimbursement only for such services and care that are supervised, ordered, or prescribed by a physician licensed under chapter 458 (M.D.) or chapter 459 (D.O.), a dentist licensed under chapter 466 (D.D.S.), or a chiropractic physician licensed under chapter 460 (D.C.) that are provided by any of the following entities:
1. A hospital or ambulatory surgical center licensed under chapter 395.
 2. A person or entity licensed under §§401.2101-401.45 that provides emergency transportation and treatment.
 3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.
 4. An entity wholly owned, directly or indirectly by a hospital or hospitals.
 5. A health care clinic licensed under §§400.990-400.995 that is:

- a. Accredited by the Joint Commission on Accreditation of Health Care Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or
- b. A health care clinic that:
 - i. Has a medical director licensed under chapter 458, chapter 459, or chapter 460
 - ii. Has been continuously licensed for more than 3 years or is a publically traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and
 - iii. Provides at least four of the following medical specialties:
 - 1. General medicine
 - 2. Radiography
 - 3. Orthopedic medicine
 - 4. Physical medicine
 - 5. Physical therapy
 - 6. Physical rehabilitation
 - 7. Prescribing or dispensing outpatient prescription medication
 - 8. Laboratory services

41. Before the 2012 PIP Act, Licensed Acupuncturists (A.P.) (Fla. Stat. chapter 457) were able to provide medical evaluation and treatment for those injured in motor vehicle accidents after appropriate referral by persons licensed under Fla. Stat. chapters 458 (M.D.), 458 (D.O.), 460 (D.C.), and 466 (D.D.S.) in hospitals and clinics owned or directed by such persons. *Id.*

42. Before the 2012 PIP Act, Licensed Massage Therapists (L.M.T.) (Fla. Stat. chapter 480) were able to provide medical evaluation and treatment for those injured in motor vehicle accidents after appropriate referral by persons licensed under Fla. Stat. chapters 458

(M.D.), 458 (D.O.), 460 (D.C.), and 466 (D.D.S.) in hospitals and clinics owned or directed by such persons. *Id.*

43. Over the past few years, several efforts were put forth by a variety of different interests to change Florida's PIP laws. On or about January 13, 2011, the Florida Office of Insurance Regulation (FLOIR) issued an industry data call to collect data necessary to evaluate concerns related to PIP insurance fraud and provided the Florida Senate with a review of PIP that is attached and incorporated into this complaint. Plaintiffs' Exhibit F: Issue Brief 2012-203 Personal Injury Protection (PIP).

44. FLOIR identified the governmental interests sought to be advanced by the 2012 PIP ACT including protecting PIP insurance companies from losing money and preventing fraud and increased medical expenses related to such fraud. *Id.*

45. The 2012 PIP Act, attached as Plaintiffs' Exhibit A and incorporated into this Complaint (and quoted directly below with **Plaintiffs' allegations describing the legislation in bold type**) is, "an act relating to motor vehicle personal injury protection insurance." The effect of the act is as follows:

- a. Amending Fla. Stat. §316.066: **(Title XXIII MOTOR VEHICLES)- This section requires written reports of crashes in State Uniform Traffic Control in the Motor Vehicles Chapter of the Florida Statutes to change the requirements related to when short-form and long-form uniform traffic control reports should be filled out and when and if penalties should be imposed upon citizens for not self-reporting a motor vehicle collision, results in:**

- i. revising conditions for completing long-form traffic crash report;

- ii. revising the information contained in the short-form and long-form reports; and,
 - iii. revising the requirements relating to driver's responsibility for submitting a report for crashes nor requiring a law enforcement report.
- b. Amending Fla. Stat. §400.9905, **(Title XXIX PUBLIC HEALTH)- This section sets forth the Health Care Clinic Act definitions which are part of the Nursing Homes and Related Health Care Facilities**, by providing that certain entities exempt from licensure as a health care clinic must nonetheless actually be licensed as a health care clinic in order to receive reimbursement for the provision of personal injury protection benefits;
- c. Amending Fla. Stat. 400.991, **(Title XXIX PUBLIC HEALTH)- This section sets forth the Health Care Clinic Act license requirements which are part of the Nursing Homes and Related Health Care Facilities**, by requiring that an application for licensure, or exemption from licensure, as a health care clinic include a statement regarding insurance fraud specifically only relating to personal injury insurance;
- d. Amending Fla. Stat. 626.989, **(Title XXXVII INSURANCE)- This section sets forth a description of Unfair Insurance Trade Practices Act which is part of the Insurance Field Representatives and Operations Chapter of the Florida Statutes**, providing that knowingly submitting false, misleading, or fraudulent documents related to licensure as a health care clinic, or submitting a claim for personal injury protection relating to clinic licensure documents is a fraudulent insurance act under certain conditions;

- e. Amending Fla. Stat. 626.9541, (Title XXXVII INSURANCE)- This section sets forth a description of Unfair Insurance Trade Practices Act which is part of the Insurance Field Representatives and Operations Chapter of the Florida Statutes, specifying an additional unfair claim settlement practice;
- f. Creating Fla. Stat. 626.9895, (Title XXXVII INSURANCE)- This section sets forth a description of Unfair Insurance Trade Practices Act which is part of the Insurance Field Representatives and Operations Chapter of the Florida Statutes:
 - i. providing definitions;
 - ii. authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud;
 - iii. providing requirements for, and duties of, the organization;
 - iv. requiring that the organization operate pursuant to a contract with the division;
 - v. providing for the requirements of the contract;
 - vi. providing for a board of directors;
 - vii. authorizing the organization to use the division's property and facilities subject to certain requirements;
 - viii. requiring that the department adopt rules relating to procedures for the organization's governance and relating to conditions for use of the division's property or facilities;

- ix. authorizing contributions from insurers;
 - x. authorizing any moneys received by the organization to be held in a separate depository account in the name of the organization;
 - xi. requiring that the division deposit certain proceeds into the Insurance Regulatory Trust Fund.
- g. **Creating Fla. Stat. §627.311 (Title XXXVII INSURANCE) – This Section sets forth, in Part I, Rates and Rating Organizations relating to joint underwriters and reinsurers, public records and meetings exemptions in the Insurance Rates and Contracts Chapter of the Florida Statutes, which results in:**
- i. specifying the effects of the Florida Motor Vehicle No-Fault Law;
 - ii. requiring compliance with provisions regardless of their expression in policy forms.
- h. **Amending Fla. Stat. §627.732 (Title XXXVII INSURANCE)- This Section sets forth, in Part XI Motor Vehicle and Casualty Insurance Contracts in the definitions section in the Insurance Rates and Contracts Chapter of the Florida Statutes: providing amended definitions**
- i. **Amending Fla. Stat. §627.736 (Title XXXVII INSURANCE) - This Section sets forth, in Part XI Motor Vehicle and Casualty Insurance Contracts in the required personal injury protection benefits, exclusions; priority; and claims section in the Insurance Rates and Contracts Chapter of the Florida Statutes, which results in:**

- i. revising the cap on benefits to provide that death benefits are in addition to medical and disability benefits;
- ii. revising medical benefits;
- iii. distinguishing between initial and followup services;
- iv. excluding massage and acupuncture from medical benefits that may be reimbursed under the Florida Motor Vehicle No-Fault Law;
- v. adding physical therapists to the list of providers that may provide services;
- vi. requiring that an insurer repay any benefits covered by the Medicaid program;
- vii. requiring that an insurer provide a claimant an opportunity to revise claims that contain errors;
- viii. authorizing an insurer to provide notice to the claimant and conduct an investigation if fraud is suspected;
- ix. requiring that an insurer create and maintain a log of personal injury benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log if litigation is commenced;
- x. revising the Medicare fee schedules that an insurer may use as a basis for limiting reimbursement of personal injury protection benefits;
- xi. providing that the Medicare fee schedule in effect on a specific date applies for purposes of limiting reimbursement;

- xii. requiring that an insurer that limits payments based on the statutory fee schedule include a notice in insurance policies at the time of issuance or renewal;
- xiii. deleting obsolete provisions;
- xiv. providing that certain entities exempt from licensure as a clinic must nonetheless be licensed to receive reimbursement for the provision of personal injury protection benefits; providing exceptions requiring that an insurer notify parties in disputes over personal injury protection claims when policy limits are reached;
- xv. providing that an insured must comply with the terms of the policy, including submission to examinations under oath;
- xvi. requiring that an insured not fail to appear at an examination;
- xvii. providing for a rebuttable presumption that a refusal of or failure to appear at an examination is unreasonable in certain circumstances;
- xviii. providing criteria for the award of attorney fees;
- xix. providing a presumption regarding the use of contingency risk multiplier;
- xx. consolidating provisions relating to unfair or deceptive practices under certain conditions;
- xxi. specifying that claims generated as a result of certain unlawful activities are not reimbursable;
- xxii. eliminating a requirement that all parties mutually and expressly agree to the use of electronic transmission of data.

- j. Amending Fla. Stat. §627.7405 (Title XXXVII INSURANCE)- This Section sets forth, in Part XI Motor Vehicle and Casualty Insurance Contracts in the insurer's right of reimbursement section in the Insurance Rates and Contracts Chapter of the Florida Statutes an exception from an insurer's right of reimbursement for certain owners or registrants;
- k. Amending Fla. Stat. §817.234 (Title XLVI CRIMES)- This Section sets forth, in Part I False Pretenses and Frauds, Generally, in the Fraudulent Practices Chapter of the Florida Statutes, which results in:
 - i. providing that it is insurance fraud to present a claim for personal injury protection benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents relating to licensure as a health care clinic;
 - ii. providing that a licensed health care practitioner guilty of certain insurance fraud loses his or her license and may not receive reimbursement for personal injury protection benefits for a specified period;
 - iii. defining the term, "insurer."
- l. Amending Fla. Stat. §316.065: (Title XXIII MOTOR VEHICLES)- This Section sets forth provisions regarding Crashes; reports; penalties in State Uniform Traffic Control in the Motor Vehicles Chapter of the Florida Statutes, and results in:
 - i. conforming a cross-reference;

- ii. authorizing the Office of Insurance Regulation to make contracts for certain purposes;
- iii. requiring a report;
- iv. requiring insurers writing private passenger automobile personal injury protection insurance to make certain rate filings;
- v. providing sanctions for failure to make the filings as required;
- vi. providing an appropriation;
- vii. requiring for carry-forward of any unexpended balance of the appropriation;
- viii. requiring that the Office of Insurance Regulation perform a data call relating to personal injury protection;
- ix. prescribing required elements of the data call;
- x. providing for severability;
- xi. providing effective dates.

46. The 2012 PIP Act imposes sweeping changes along with significant restrictions on both healthcare providers and healthcare consumers – changes dramatically limiting Floridian’s efficient and unfettered access to healthcare following motor vehicle accidents – such efficient and unfettered access that comprised the initial tradeoff between consumer’s access to the courts and the PIP/no-fault system in the first place.

47. Amongst other changes and limitations, the 2012 PIP Act:

- a. Alters the way written crash reports are to be taken and imposes consumer penalties for failing to follow the new rules;

- b. Redefines which clinics may provide healthcare only for those injured as a result of a motor vehicle collision;
- c. Creates and defines a litany of fraudulent insurance acts outside those already criminalized by the Florida Statutes;
- d. Creates an entirely new administrative agency for the specific purpose of prosecuting, investigating and preventing motor vehicle fraud and allows those benefiting from this new agency, i.e. PIP insurance carriers, to contribute financially to this new administrative agency;
- e. Requires that any outstanding contracts between PIP insurance carriers and consumers conform to these new rules (see also emergency rule making below);
- f. Eliminates all Florida Licensed Acupuncture Physicians from providing any healthcare to Floridians injured as a result of a motor vehicle collision;
- g. Eliminates all Florida Licensed Massage Therapists from providing any healthcare to Floridians injured as a result of a motor vehicle collision;
- h. Limits all Florida Chiropractors to providing only spinal manipulation as permitted under the regulations set forth by the Centers for Medicare and Medicaid Services (CMS);
- i. Permits physical therapists to provide services following appropriate referral – services that are already ;
- j. Imposes procedural requirements and limitations on PIP insurers and adopts CMS fee schedules;
- k. Alters evidentiary burdens and creates rebuttable presumptions for Floridians' compliance with PIP insurer ordered independent medical examinations;

- l. Alters attorneys' fee provisions for plaintiffs attorneys;
- m. Alters unfair and deceptive trade practices independent of the Florida Unfair and Deceptive Trade Practice Act;
- n. Alters professional licensure requirements and qualifications related to insurance fraud and/or submission of false, misleading or fraudulent documents;
- o. Continues to require that all Floridians purchase \$10,000.00 (ten thousand dollars) in PIP insurance coverage but limits such coverage depending on when that Floridian seeks treatment and who provides it.
 - i. Full coverage, \$10,000.00 (ten thousand dollars) is only available for those with poorly defined emergency medical conditions seeking initial evaluation and care within fourteen (14) days of a motor vehicle collision by an M.D., a D.O., or a D.D.S.
 - ii. 75% coverage, \$2,500.00 (two thousand five hundred dollars) is only available for those seeking coverage within fourteen (14) days of a motor vehicle collision without an emergency medical condition by an M.D., a D.O., or a D.D.S.
 - iii. In all cases, seeking initial evaluation and care by a D.C. will only provide 75% coverage \$2,500.00 (two thousand five hundred dollars) as long as evaluation and treatment are sought within fourteen (14) days of the initial accident.
 - iv. No coverage will be provided for care provided if care is sought greater than fourteen (14) days after the initial accident.

48. Importantly, the 2012 PIP Act provides absolutely no data that

- i. Care sought fourteen (14) days after a motor vehicle accident is neither necessary nor worthy of being evaluated and treated;
- ii. Acupuncture therapy is neither beneficial nor helpful for those injured by motor vehicle accidents;
- iii. Massage therapy is neither beneficial nor helpful for those injured by motor vehicle accidents;
- iv. Only spinal manipulation permitted by CMS guidelines is beneficial or helpful for those injured by motor vehicle accidents;
- v. Emergency medical conditions warrant any more care than non emergency medical conditions;
- vi. That the definitions for emergency medical conditions are accurate and applicable to motor vehicle collisions;

49. During none of the proceedings held in furtherance of the 2012 PIP Act was any competent substantial evidence put forward supporting the restrictions imposed by the 2012 PIP Act. The entire legislative records is devoid of any evidence establishing that:

- a. The conduct of all Licensed Acupuncture Physicians is the proximate cause of fraud, unjustified medical expenses, or any other governmental interests purportedly advanced by the 2012 PIP Act. Or that Acupuncture provides no compensable benefits for those injured by motor vehicle collisions.
- b. The conduct of all Licensed Massage Therapists is the proximate cause of fraud, unjustified medical expenses, or any other governmental interests purportedly advanced by the 2012 PIP Act. Or that Massage Therapy provides no compensable benefits for those injured by motor vehicle collisions.

- c. The conduct of all Licensed Chiropractic Physicians is the proximate cause of fraud, unjustified medical expenses, or any other governmental interests purportedly advanced by the 2012 PIP Act. Or that Chiropractic Medicine provides no compensable benefits for those injured by motor vehicle collisions.
50. Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA and JOHN DOE, all possessing appropriate Florida Professional Licensure, all possess a clear legal right to provide healthcare related services in their businesses and clinics. Further, the right to provide such healthcare services and seek compensation for such services is reasonable and constituted the sufficient alternative already relied upon by the courts to limit plaintiffs access to the courts as part of a no-fault scheme (PIP insurance) to provide efficient and unfettered access to healthcare following a motor vehicle collision.
51. Limiting Floridian's access to appropriate healthcare, under the guise of preventing fraud, will void the sufficient alternative relied upon by the courts and the limitations imposed by PIP insurance on every Floridian's access to the courts will become unconstitutional.
52. As a representative consumer, Plaintiff JANE DOE possesses a protected right to seek medical treatment resulting from motor vehicle collisions at a time when such conditions may manifest – with some, if not many, arguably manifesting in excess of fourteen (14) days after such accident. The time limits imposed by the legislature for receipt of PIP benefits were devoid of any basis in the legislative record reflecting that this “deadline” was based on any legitimate medical theory or good or peer-reviewed medical care.

Count I: Violations of the Florida Constitution

53. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:

54. The Florida Constitution prohibits legislation that impacts greater than one subject at a time. The 2012 PIP Act impacts 4 Titles and 10 sections of the Florida Statutes resulting in a wide variety of change(s) exceeding the **single subject rule**.
55. The 2012 PIP Act violates the Florida Constitution because it is **arbitrary and capricious** as applied to Plaintiffs' healthcare businesses and consumer's treatment deadlines.
56. The 2012 PIP Act violates the Florida Constitution because it **denies due process of law by imposing strict liability** for innocent business activities.
57. The 2012 PIP Act violates the Florida Constitution because it represents an unlawful exercise of the state's police power in that the vast changes and restrictions effected by the act have **no substantial relationship to the protection of the public health and welfare or any legitimate governmental objective**.
58. The 2012 PIP Act violates the Florida Constitution because it **denies due process by imposing inconsistent and unnecessary regulation(s) conflicting with existing statutes**.
59. The 2012 PIP Act violates the Florida Constitution because it **is specifically designed to protect the insurance industry while compromising the rights and protections due Florida's individual citizens and consumers**.

Count II: Violation of Article I §2 of the Florida Constitution

60. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:
61. Article I §2 of the Florida Constitution states that all persons are equal before the law and possess inalienable rights including those to be rewarded for industry, and those to acquire, possess and protect property.

62. The 2012 PIP Act unlawfully abridges and restrains the Plaintiffs' rights to enjoy the fruits of engaging in a lawful business.
63. The 2012 PIP Act violates this section of the Florida Constitution because it prohibits Licensed Acupuncture Physicians from either being rewarded for their industry (providing medical care) or from protecting their property right in their professional licensure (once they obtain a professional license, they possess a property right in that license). Although Licensed Acupuncture Physicians may continue to evaluate and treat those Floridians with back or neck pain, they may no longer treat (for compensation) any Floridians injured during a motor vehicle collision.
64. The 2012 PIP Act violates this section of the Florida Constitution because it prohibits Licensed Massage Therapists from either being rewarded for their industry (providing medical care) or from protecting their property right in their professional licensure (once they obtain a professional license, they possess a property right in that license). Although Licensed Massage Therapists may continue to evaluate and treat those Floridians with back or neck pain, they may no longer treat (for compensation) any Floridians injured during a motor vehicle collision.
65. The 2012 PIP Act violates this section of the Florida Constitution because it prohibits Licensed Chiropractic Physicians from either being rewarded for their industry (providing medical care) or from protecting their property right in their professional licensure (once they obtain a professional license, they possess a property right in that license). Although Licensed Chiropractic may continue to evaluate and treat those Floridians with back or neck pain, if they evaluate and treat any Floridian injured during a motor vehicle collision, that Floridian will only be entitled to 25% (twenty five percent)

coverage – a D.C. may not diagnose an emergency medical condition – only an M.D., a D.O., or a D.D.S. All Floridians must still continue to purchase \$10,000.00 (ten thousand dollars) of PIP insurance but the 2012 PIP Act interferes with contract and limits this coverage to \$2,500.00 (two thousand five hundred dollars) if the initial evaluation is performed by a Chiropractic Physician or there is no diagnosed emergency medical condition.

66. Similarly the 2012 PIP Act violates Plaintiff JOHN DOE'S rights.

67. The 2012 PIP Act violates Plaintiff JANE DOE's rights because Floridians choosing to seek a Chiropractor will automatically be entitled to 75% (seventy five percent) less coverage and because Floridians will be absolutely prevented from choosing Acupuncture Physicians and Massage Therapists after motor vehicle accidents. All despite a requirement that all Floridians purchase \$10,000.00 (ten thousand dollars) in PIP insurance.

Count III: Violation of Article I §6 of the Florida Constitution

68. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:

69. Article I §6 of the Florida Constitution states that all persons shall be permitted to work regardless of their membership in a union or labor organization.

70. The 2012 PIP Act unlawfully abridges and restrains the Plaintiffs' rights to enjoy the fruits of engaging in a lawful business.

71. Professional licensure in Florida requires that all Chiropractic Physicians, all Acupuncture Physicians and all Licensed Massage Therapists first obtain a license issued by the Florida Department of Health. Once issued, the licensee possesses a property right in that license.

72. Acupuncture Physicians, Licensed Massage Therapists, and Chiropractic Physicians each all belong to a variety of state, local, and national labor unions or labor organizations.
73. The 2012 PIP Act denies all Acupuncture Physicians the ability to earn any compensation for providing healthcare to those injured as a result of a motor vehicle collision.
74. The 2012 PIP Act denies all Licensed Massage Therapists the ability to earn any compensation for providing healthcare to those injured as a result of a motor vehicle collision.
75. The 2012 PIP Act denies all Chiropractic Physicians the ability to earn any reasonable compensation for providing healthcare to those injured as a result of a motor vehicle collision. In actuality the 2012 PIP Act dramatically limits the amount available for Chiropractic care and bases such amount on federal CMS fee schedules.

Count IV: Violation of Article I §9 of the Florida Constitution

76. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:
77. Article I §9 of the Florida Constitution states that no person shall be deprived of life, liberty or property without due process of law.
78. The 2012 PIP Act deprives all Acupuncture Physicians of due process of law by limiting their professional licensure and preventing them from providing healthcare only to those injured as a result of a motor vehicle collision – completely in the absence of a compelling state interest and without a rational basis.
79. The 2012 PIP Act deprives all Licensed Massage Therapists of due process of law by limiting their professional licensure and preventing them from providing healthcare only to those injured as a result of a motor vehicle collision - completely in the absence of a compelling state interest and without a rational basis.

80. The 2012 PIP Act deprives all Chiropractic Physicians of due process of law by limiting their professional licensure and preventing them from providing healthcare only to those injured as a result of a motor vehicle collision, completely in the absence of any compelling state interest and without a rational basis.

Count V: Violation of Article I §10 of the Florida Constitution

81. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:

82. Article I §1 of the Florida Constitution prohibits any law interfering with contract.

83. Plaintiff JANE DOE possessed a contract with the provider of her required PIP insurance to provide the statutorily required \$10,000.00 (ten thousand dollars) of coverage. Here, the 2012 PIP Act impermissibly interfered with this contract. Defendant was part of an emergency rule making by the Florida Cabinet in December 2012 that permitted PIP insurance carriers to unilaterally re-write the small print between it and its insureds allowing the PIP insurers to provide less than the purchased coverage amount.

84. Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA, and JOHN DOE all possess ongoing business and contractual relationships with those injured as a result of a prior motor vehicle collision. The 2012 PIP Act interferes with these already established relationships and contracts.

Count VI: Violation of Article I §21 of the Florida Constitution

85. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:

86. Article I §21 of the Florida Constitution requires that the courts be available to any citizen. The original no-fault scheme underlying the genesis of PIP insurance determined that efficient and unfettered access to healthcare constituted a sufficient alternative to access to the courts – and PIP insurance was upheld. Now, however, the legislature is

effectively undoing this sufficient alternative by decreasing and limiting Floridians efficient and unfettered access to healthcare.

87. Accordingly in addition to voiding the 2012 PIP Act, in the alternative that the 2012 PIP Act is upheld, the entire PIP Act should be held unconstitutional because of its limiting of Floridian's access to the courts in the absence of a sufficient alternative.

Count VII: Violation of Article II §3 of the Florida Constitution

88. Plaintiffs reincorporate and reallege paragraphs 1 through 51 above and further state:

89. Article II §3 of the Florida Constitution requires separation of powers.

90. The 2012 PIP Act changes definitions for fraud and insurance fraud and prescribes administrative licensure limitations as a result of judicial findings.

91. The 2012 PIP Act creates a new executive agency with judicial powers to oversee PIP fraud that may also accept funding from PIP insurers.

92. The 2012 PIP Act legislatively imposes a statute defining the amount of damages an injured party may claim; also limiting that party's access to the courts.

Demand for Jury Trial

Plaintiffs respectfully demand a jury trial on all issues so triable.

Prayer for Relief

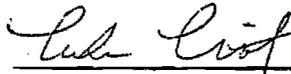
Wherefore, Plaintiffs respectfully request that this Court grant the following relief:

- a. Declare the 2012 PIP ACT unconstitutional for the above listed reasons; and
- b. Entertain immediate proceedings for the issuance of a Temporary and Permanent Injunction enjoining the enforcement of the 2012 PIP Act; and
- c. Awarding any and all attorney's fees and costs as authorized by law; and

- d. Awarding any and all actual, consequential, and special damages to which Plaintiffs are entitled; and
- e. Awarding any other such relief as this Court deems fit, just and equitable.

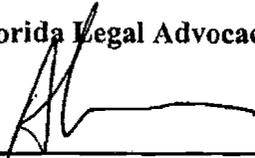
Respectfully submitted this 7th day of January 2013

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CHAPTER 2012-197

Committee Substitute for Committee Substitute for House Bill No. 119

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising the conditions for completing the long-form traffic crash report; revising the information contained in the short-form and long-form reports; revising the requirements relating to the driver's responsibility for submitting a report for crashes not requiring a law enforcement report; amending s. 400.9905, F.S.; providing that certain entities exempt from licensure as a health care clinic must nonetheless be licensed in order to receive reimbursement for the provision of personal injury protection benefits; amending s. 400.991, F.S.; requiring that an application for licensure, or exemption from licensure, as a health care clinic include a statement regarding insurance fraud; amending s. 626.989, F.S.; providing that knowingly submitting false, misleading, or fraudulent documents relating to licensure as a health care clinic, or submitting a claim for personal injury protection relating to clinic licensure documents, is a fraudulent insurance act under certain conditions; amending s. 626.9541, F.S.; specifying an additional unfair claim settlement practice; creating s. 626.9895, F.S.; providing definitions; authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for, and duties of, the organization; requiring that the organization operate pursuant to a contract with the division; providing for the requirements of the contract; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; requiring that the department adopt rules relating to procedures for the organization's governance and relating to conditions for the use of the division's property or facilities; authorizing contributions from insurers; authorizing any moneys received by the organization to be held in a separate depository account in the name of the organization; requiring that the division deposit certain proceeds into the Insurance Regulatory Trust Fund; creating s. 627.7311, F.S.; specifying the effects of the Florida Motor Vehicle No-Fault Law; requiring compliance with provisions regardless of their expression in policy forms; amending s. 627.732, F.S.; providing definitions; amending s. 627.736, F.S.; revising the cap on benefits to provide that death benefits are in addition to medical and disability benefits; revising medical benefits; distinguishing between initial and followup services; excluding massage and acupuncture from medical benefits that may be reimbursed under the Florida Motor Vehicle No-Fault Law; adding physical therapists to the list of providers that may provide services; requiring that an insurer repay any benefits covered by the Medicaid program; requiring that an insurer provide a claimant an opportunity to revise claims that contain errors; authorizing an insurer to provide notice to the claimant and conduct an investigation if fraud is

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suspected; requiring that an insurer create and maintain a log of personal injury protection benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log if litigation is commenced; revising the Medicare fee schedules that an insurer may use as a basis for limiting reimbursement of personal injury protection benefits; providing that the Medicare fee schedule in effect on a specific date applies for purposes of limiting reimbursement; requiring that an insurer that limits payments based on the statutory fee schedule include a notice in insurance policies at the time of issuance or renewal; deleting obsolete provisions; providing that certain entities exempt from licensure as a clinic must nonetheless be licensed to receive reimbursement for the provision of personal injury protection benefits; providing exceptions; requiring that an insurer notify parties in disputes over personal injury protection claims when policy limits are reached; providing that an insured must comply with the terms of the policy, including submission to examinations under oath; requiring that an insured not fail to appear at an examination; providing for a rebuttable presumption that a refusal of or failure to appear at an examination is unreasonable in certain circumstances; providing criteria for the award of attorney fees; providing a presumption regarding the use of a contingency risk multiplier; consolidating provisions relating to unfair or deceptive practices under certain conditions; specifying that claims generated as a result of certain unlawful activities are not reimbursable; eliminating a requirement that all parties mutually and expressly agree to the use of electronic transmission of data; amending s. 627.7405, F.S.; providing an exception from an insurer's right of reimbursement for certain owners or registrants; amending s. 817.234, F.S.; providing that it is insurance fraud to present a claim for personal injury protection benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents relating to licensure as a health care clinic; providing that a licensed health care practitioner guilty of certain insurance fraud loses his or her license and may not receive reimbursement for personal injury protection benefits for a specified period; defining the term "insurer"; amending s. 316.065, F.S.; conforming a cross-reference; authorizing the Office of Insurance Regulation to make contracts for certain purposes; requiring a report; requiring insurers writing private passenger automobile personal injury protection insurance to make certain rate filings; providing sanctions for failure to make the filings as required; providing an appropriation; providing for carryforward of any unexpended balance of the appropriation; requiring that the Office of Insurance Regulation perform a data call relating to personal injury protection; prescribing required elements of the data call; providing for severability; providing effective dates.

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

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

316.066 Written reports of crashes.—

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

1. Resulted in death 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. Involved a violation of s. 316.061(1) or s. 316.193;
3. Rendered a vehicle inoperable to a degree that required a wrecker to remove it from the scene of the crash; or
4. Involved a commercial motor vehicle.

(b) The Florida Traffic Crash Report, 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, including all drivers and passengers, and the identification of the vehicle in which each was a driver or a passenger.
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.

~~(c)(b)~~ In any every crash for which a Florida Traffic Crash Report, Long Form is not required by this section and which occurs on the public roadways of this state, the law enforcement officer ~~shall~~ may complete a short-form crash report or provide a driver exchange-of-information form, to be completed by all drivers and passengers each party involved in the crash, which requires the identification of each vehicle that the drivers and passengers were in. The short-form report must include:

1. The date, time, and location of the crash.
2. A description of the vehicles involved.
3. The names and addresses of the parties involved, including all drivers and passengers, and the identification of the vehicle in which each was a driver or a passenger.
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)~~(e) Each party to the crash must provide the law enforcement officer with proof of insurance, which must be documented in the crash report. If a law enforcement officer submits a report on the crash, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If 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 a any vehicle or other property which does not require a law enforcement report in an amount of \$500 or more which was not investigated by a law enforcement agency, shall, within 10 days after the crash, submit a written report of the crash to the department. The report shall be submitted on a form approved by the department. The entity receiving the report may require witnesses of the crash to render reports and may require any driver of a vehicle involved in a crash of which a written report must be made to file supplemental written reports if the original report is deemed insufficient by the receiving entity.

~~(f)~~(e) Long-form and short-form crash reports prepared by law enforcement must be submitted to the department and may shall be maintained by the law enforcement officer's agency.

Section 2. Subsection (4) of section 400.9905, Florida Statutes, is amended to read:

400.9905 Definitions.—

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

(a) Entities licensed or registered by the state under chapter 395; ~~or~~ entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses ~~granted~~ under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651;

end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; ~~or~~ entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees at least ~~not less than~~ two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy

services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner ~~if, so long as~~ one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) which ~~that~~ provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic or prosthetic clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation

is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, unless exempted under s. 627.736(5)(h).

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

400.991 License requirements; background screenings; prohibitions.—

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

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

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

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

(1) For the purposes of this section,;

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

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

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2. Knowingly submits:

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

b. A claim for payment or other benefit pursuant to a personal injury protection insurance policy under the Florida Motor Vehicle No-Fault Law if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400. For the purposes of this section,

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

Section 5. Paragraph (i) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

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

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

- b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- c. Failing to acknowledge and act promptly upon communications with respect to claims;
- d. Denying claims without conducting reasonable investigations based upon available information;
- e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;
- f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;
- g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or
- h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.
- i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

Section 6. Subsection (5) of section 626.9894, Florida Statutes, is amended to read:

626.9894 Gifts and grants.—

(5) ~~Notwithstanding the provisions of s. 216.301 and pursuant to s. 216.351, any balance of moneys deposited into the Insurance Regulatory~~

Trust Fund pursuant to this section ~~or s. 626.9895~~ remaining at the end of any fiscal year ~~is shall be~~ available for carrying out the duties and responsibilities of the division. The department may request annual appropriations from the grants and donations received pursuant to this section ~~or s. 626.9895~~ and cash balances in the Insurance Regulatory Trust Fund for the purpose of carrying out its duties and responsibilities related to the division's anti-fraud efforts, including the funding of dedicated prosecutors and related personnel.

Section 7. Section 626.9895, Florida Statutes, is created to read:

626.9895 Motor vehicle insurance fraud direct-support organization.—

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

(a) "Division" means the Division of Insurance Fraud of the Department of Financial Services.

(b) "Motor vehicle insurance fraud" means any act defined as a "fraudulent insurance act" under s. 626.989, which relates to the coverage of motor vehicle insurance as described in part XI of chapter 627.

(c) "Organization" means the direct-support organization established under this section.

(2) ORGANIZATION ESTABLISHED.—The division may establish a direct-support organization, to be known as the "Automobile Insurance Fraud Strike Force," whose sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The organization shall:

(a) Be a not-for-profit corporation incorporated under chapter 617 and approved by the Department of State.

(b) Be organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and make grants and expenditures to or for the direct or indirect benefit of the division, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration, and the Department of Health to the extent that such grants and expenditures are used exclusively to advance the prosecution, investigation, or prevention of motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of motor vehicle insurance fraud investigators, prosecutors, or support personnel if such grants and expenditures do not interfere with prosecutorial independence or otherwise create conflicts of interest which threaten the success of prosecutions.

(c) Be determined by the division to operate in a manner that promotes the goals of laws relating to motor vehicle insurance fraud, that is in the best

interest of the state, and that is in accordance with the adopted goals and mission of the division.

(d) Use all of its grants and expenditures solely for the purpose of preventing and decreasing motor vehicle insurance fraud, and not for advertising using the likeness or name of any elected official nor for the purpose of lobbying as defined in s. 11.045.

(e) Be subject to an annual financial audit in accordance with s. 215.981.

(3) CONTRACT.—The organization shall operate under written contract with the division. The contract must provide for:

(a) Approval of the articles of incorporation and bylaws of the organization by the division.

(b) Submission of an annual budget for approval of the division. The budget must require the organization to minimize costs to the division and its members at all times by using existing personnel and property and allowing for telephonic meetings if appropriate.

(c) Certification by the division that the organization is complying with the terms of the contract and in a manner consistent with the goals and purposes of the department and in the best interest of the state. Such certification must be made annually and reported in the official minutes of a meeting of the organization.

(d) Allocation of funds to address motor vehicle insurance fraud.

(e) Reversion of moneys and property held in trust by the organization for motor vehicle insurance fraud prosecution, investigation, and prevention to the division if the organization is no longer approved to operate for the department or if the organization ceases to exist, or to the state if the division ceases to exist.

(f) Specific criteria to be used by the organization's board of directors to evaluate the effectiveness of funding used to combat motor vehicle insurance fraud.

(g) The fiscal year of the organization, which begins July 1 of each year and ends June 30 of the following year.

(h) Disclosure of the material provisions of the contract, and distinguishing between the department and the organization to donors of gifts, contributions, or bequests, including providing such disclosure on all promotional and fundraising publications.

(4) BOARD OF DIRECTORS.—

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

1. The Chief Financial Officer, or designee, who shall serve as chair.
 2. Two state attorneys, one of whom shall be appointed by the Chief Financial Officer and one of whom shall be appointed by the Attorney General.
 3. Two representatives of motor vehicle insurers appointed by the Chief Financial Officer.
 4. Two representatives of local law enforcement agencies, one of whom shall be appointed by the Chief Financial Officer and one of whom shall be appointed by the Attorney General.
 5. Two representatives of the types of health care providers who regularly make claims for benefits under ss. 627.730-627.7405, one of whom shall be appointed by the President of the Senate and one of whom shall be appointed by the Speaker of the House of Representatives. The appointees may not represent the same type of health care provider.
 6. A private attorney that has experience in representing claimants in actions for benefits under ss. 627.730-627.7405, who shall be appointed by the President of the Senate.
 7. A private attorney who has experience in representing insurers in actions for benefits under ss. 627.730-627.7405, who shall be appointed by the Speaker of the House of Representatives.
 - (b) The officer who appointed a member of the board may remove that member for any reason. The term of office of an appointed member expires at the same time as the term of the officer who appointed him or her or at such earlier time as the person ceases to be qualified.
- (5) USE OF PROPERTY.—The department may authorize, without charge, appropriate use of fixed property and facilities of the division by the organization, subject to this subsection.
- (a) The department may prescribe any condition with which the organization must comply in order to use the division's property or facilities.
 - (b) The department may not authorize the use of the division's property or facilities if the organization does not provide equal membership and employment opportunities to all persons regardless of race, religion, sex, age, or national origin.
 - (c) The department shall adopt rules prescribing the procedures by which the organization is governed and any conditions with which the organization must comply to use the division's property or facilities.
- (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an insurer to the organization shall be allowed as an appropriate business expense of the insurer for all regulatory purposes.

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

(8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by the division from the organization shall be deposited into the Insurance Regulatory Trust Fund.

Section 8. Section 627.7311, Florida Statutes, is created to read:

627.7311 Effect of law on personal injury protection policies.—The provisions and procedures authorized in ss. 627.730-627.7405 shall be implemented by insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Law. The Legislature intends that these provisions and procedures have full force and effect regardless of their express inclusion in an insurance policy form, and a specific provision or procedure authorized in ss. 627.730-627.7405 shall control over general provisions in an insurance policy form. An insurer is not required to amend its policy form or to expressly notify providers, claimants, or insureds in order to implement and apply such provisions or procedures.

Section 9. Effective January 1, 2013, subsections (16) and (17) are added to section 627.732, Florida Statutes, to read:

627.732 Definitions.—As used in ss. 627.730-627.7405, the term:

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

- (a) Serious jeopardy to patient health.
- (b) Serious impairment to bodily functions.
- (c) Serious dysfunction of any bodily organ or part.

(17) "Entity wholly owned" means a proprietorship, group practice, partnership, or corporation that provides health care services rendered by licensed health care practitioners and in which licensed health care practitioners are the business owners of all aspects of the business entity, including, but not limited to, being reflected as the business owners on the title or lease of the physical facility, filing taxes as the business owners, being account holders on the entity's bank account, being listed as the principals on all incorporation documents required by this state, and having ultimate authority over all personnel and compensation decisions relating to the entity. However, this definition does not apply to an entity that is wholly owned, directly or indirectly, by a hospital licensed under chapter 395.

Section 10. Effective January 1, 2013, subsections (1), (4), (5), (6), (7), (8), (9), (10), and (11) of section 627.736, Florida Statutes, are amended, and subsection (17) is added to that section, to read:

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

(1) **REQUIRED BENEFITS.**—~~An Every~~ insurance policy complying with the security requirements of s. 627.733 ~~must shall~~ provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in ~~the such~~ motor vehicle, and other persons struck by ~~the such~~ motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the ~~provisions of~~ subsection (2) and paragraph (4)(e), to a limit of \$10,000 in ~~medical and disability benefits and \$5,000 in death benefits resulting from for loss sustained by any such person as a result of~~ bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services ~~if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident.~~ However, The medical benefits shall provide reimbursement only for: such

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a.1. A hospital or ambulatory surgical center licensed under chapter 395.

~~2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.~~

b.3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of such that practitioner or these practitioners.

c.4. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in subparagraph 2.

e.5. A health care clinic licensed under part X of chapter 400 which ss. 400.990-400.995 that is:

a. accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.,; or

~~b. A health care clinic that:~~

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to \$10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to \$2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) *Disability benefits.*—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must shall be paid at least not less than every 2 weeks.

(c) *Death benefits.*—~~Death benefits equal to the lesser of \$5,000 or the remainder of unused personal injury protection benefits per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy.~~ The insurer may pay ~~death such~~ benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, or legal adoption, or ~~connection by~~ marriage, or to any person appearing to the insurer to be equitably entitled to such benefits thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurer may not shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than \$10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance

coverage available through normal marketing channels. An Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates shall be deemed to have violated part IX of chapter 626, and such violation constitutes shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An; and any such insurer committing such violation is shall be subject to the penalties provided under that afforded in such part, as well as those provided which may be afforded elsewhere in the insurance code.

(4) PAYMENT OF BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 are shall be primary, except that benefits received under any workers' compensation law must shall be credited against the benefits provided by subsection (1) and are shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are shall be subject to the provisions of the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section are shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. However:

1. If such written notice of the entire claim is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer.

2. If When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if, provided that this does shall not limit the introduction of evidence at trial, and The insurer must also shall include the name and address of the person to whom the claimant

should respond and a claim number to be referenced in future correspondence.

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

~~4. However, Notwithstanding the fact that written notice has been furnished to the insurer, any payment is shall not be deemed overdue if when the insurer has reasonable proof to establish that the insurer is not responsible for the payment.~~

5. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument that which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

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

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve \$5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002(9), or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims ~~a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care~~ may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits are ~~shall be~~ tolled for the period of time that an insurer is required by ~~this paragraph~~ to hold payment of a claim that is not from such a physician or dentist ~~who provided emergency services and care or who provided hospital inpatient care~~ to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

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

(e) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., if provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, if provided the injured person is not himself or herself:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.

(f) If two or more insurers are liable for paying to pay personal injury protection benefits for the same injury to any one person, the maximum payable is shall be as specified in subsection (1), and the any insurer paying the benefits is shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits are shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his

or her policy, if the fraud is admitted to in a sworn statement by the insured or if it is established in a court of competent jurisdiction. Any insurance fraud ~~voids~~ shall void all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid ~~before~~ prior to the discovery of the insured person's insurance fraud ~~is~~ shall be recoverable by the insurer ~~in its entirety~~ from the person who committed insurance fraud ~~in their entirety~~. The prevailing party is entitled to its costs and ~~attorney~~ attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

~~(a) A~~ A Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment; if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such a charge ~~may not exceed~~ may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. ~~In determining~~ With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle ~~automobile~~ and other

insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

~~1.2.~~ The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

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

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

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

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

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

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

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

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

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

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

~~2.3.~~ For purposes of subparagraph ~~1. 2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which at the time the services, supplies, or care is were rendered, and the applicable fee schedule or payment limitation

applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3.4. Subparagraph 1. 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

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

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

- (b)1. An insurer or insured is not required to pay a claim or charges:
- a. Made by a broker or by a person making a claim on behalf of a broker;
 - b. For any service or treatment that was not lawful at the time rendered;
 - c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;
 - d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);
 - e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly

upcoded or unbundled; and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, ~~if, provided that before doing so, the insurer~~ contacts must contact the health care provider and ~~discusses discuss~~ the reasons for the insurer's change and the health care provider's reason for the coding, or ~~makes make~~ a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. ~~The initial list shall be adopted by January 1, 2004, and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may shall not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an any invalid diagnostic test as determined by the Department of Health.~~

~~(c)1.~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

~~1.2.~~ If, ~~however,~~ the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes

with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

- a. A denial letter from the incorrect insurer; or
- b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

~~2.3.~~ For emergency services and care as defined in ~~s. 395.002~~ rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph,~~;~~ and the insurer ~~is~~ shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the federal Centers for Medicare and Medicaid Services Health-Care-Finance-Administration.

~~3.4.~~ Each notice of ~~the~~ insured's rights under s. 627.7401 must include the following statement in at least 12-point type in type no smaller than 12 points:

BILLING REQUIREMENTS.—Florida law provides ~~Statutes provide~~ that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

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

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

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

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

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

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

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

6. ~~The~~ This disclosure and acknowledgment form is not required for services billed by a provider ~~for emergency services as defined in s. 395.002,~~ for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form ~~to that shall~~ be used to fulfill the requirements of this paragraph, ~~effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.~~

8. As used in this paragraph, the term "countersign" or "countersignature" "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which that is consistent with the services being rendered to the patient as claimed. The requirement to maintain requirements of this subparagraph ~~for maintaining~~ a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification, and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to ~~a such~~ written notification by any person, the insurer shall pay

to the person 20 percent of the amount of the reduction, up to \$500. If the provider is arrested due to the improper billing, then the insurer shall pay to the person 40 percent of the amount of the reduction, up to \$500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

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

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

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

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

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

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

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

(a) ~~Every employer shall,~~ If a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, an employer must furnish forthwith, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested ~~to do so~~ by the insurer against whom the claim has been made, furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer

were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce ~~forthwith~~, and allow permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment ~~if, provided that this does~~ shall not limit the introduction of evidence at trial. Such sworn statement must shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount ~~that~~ which is the subject of the insurer's inquiry ~~is~~ shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in ~~For purposes of~~ this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

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

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under ~~the provisions of~~ this section, and ~~shall~~ pay a reasonable charge, if required by the insurer.

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

(f) In a dispute between the insured and the insurer, or between an assignee of the insured's rights and the insurer, upon request, the insurer

must notify the insured or the assignee that the policy limits under this section have been reached within 15 days after the limits have been reached.

(g) An insured seeking benefits under ss. 627.730-627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

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

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, ~~then~~ such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical

conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; 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.

(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 or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY ATTORNEY FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of ss. s. 627.428 and 768.79 shall apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and ~~contract enter into contracts~~ with preferred licensed health care providers for the benefits described in this section, ~~referred to in this section as “preferred providers,”~~ which shall include health care providers licensed under chapter chapters 458, chapter 459, chapter 460, chapter 461, or chapter and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer’s principal office of ~~the insurer~~ within the state.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, ~~the insurer must be provided with~~ written notice of an intent to initiate litigation must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice must ~~required shall~~ state that it is a “demand letter under s. 627.736(10)” and shall state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.

2. The claim number or policy number upon which such claim was originally submitted to the insurer.

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the designated person to whom notices must pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 are shall be deemed the authorized representative to accept notice pursuant to this subsection ~~if in the event~~ no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of \$250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of \$250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty ~~is~~ shall not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any ~~attorney~~ attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

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

~~(f) Any insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.~~

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

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

1. Fails to pay valid claims for personal injury protection; or
2. Fails to pay valid claims until receipt of the notice required by subsection (10).

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

(17) NONREIMBURSIBLE CLAIMS.—Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

Section 11. Effective December 1, 2012, subsection (16) of section 627.736, Florida Statutes, is amended to read:

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

~~(16) SECURE ELECTRONIC DATA TRANSFER.—If all parties mutually and expressly agree, A notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.~~

Section 12. Section 627.7405, Florida Statutes, is amended to read:

627.7405 Insurers' right of reimbursement.—

~~(1) Notwithstanding any other provisions of ss. 627.730-627.7405, an any insurer providing personal injury protection benefits on a private passenger motor vehicle shall have, to the extent of any personal injury protection~~

benefits paid to any person as a benefit arising out of such private passenger motor vehicle insurance, a right of reimbursement against the owner or the insurer of the owner of a commercial motor vehicle, if the benefits paid result from such person having been an occupant of the commercial motor vehicle or having been struck by the commercial motor vehicle while not an occupant of any self-propelled vehicle.

(2) The insurer's right of reimbursement under this section does not apply to an owner or registrant as identified in s. 627.733(1)(b).

Section 13. Subsections (1), (10), and (13) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

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

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

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

3.a. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract; or

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

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

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

(10) ~~A licensed health care practitioner who is found guilty of insurance fraud under this section for an act relating to a personal injury protection insurance policy loses his or her license to practice for 5 years and may not receive reimbursement for personal injury protection benefits for 10 years. As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(13) As used in this section, ~~the term:~~

(a) ~~"Insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(b)(a) "Property" means property as defined in s. 812.012.

(c)(b) "Value" means value as defined in s. 812.012.

Section 14. Subsection (4) of section 316.065, Florida Statutes, is amended to read:

316.065 Crashes; reports; penalties.—

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

Section 15. (1) ~~Within 60 days after the effective date of this section, the Office of Insurance Regulation shall enter into a contract with an independent consultant to calculate the savings expected as a result of this act. The contract shall require the use of generally accepted actuarial techniques and standards as provided in s. 627.0651, Florida Statutes, in determining the expected impact on losses and expenses. By September 15, 2012, the office shall submit to the Governor, the President of Senate, and the Speaker of the House of Representatives a report concerning the results of the independent consultant's calculations.~~

(2) By October 1, 2012, an insurer writing private passenger automobile personal injury protection insurance in this state shall make a rate filing with the Office of Insurance Regulation. A rate certification is not sufficient to satisfy this requirement. If the insurer requests a rate in excess of a 10-percent reduction as applied to the current rate in its overall base rate for personal injury protection insurance, the insurer must include in its rate filing a detailed explanation of the reasons for failure to achieve a 10-percent reduction.

(3) By January 1, 2014, an insurer writing private passenger automobile personal injury protection insurance in this state shall make a rate filing with the Office of Insurance Regulation. A rate certification is not sufficient to satisfy this requirement. If the insurer requests a rate in excess of a 25-percent reduction as applied to the rate in effect as of the effective date of this act in its overall base rate for personal injury protection insurance since the effective date of this act, the insurer must include in its rate filing a detailed explanation of the reasons for failure to achieve a 25-percent reduction.

(4) If an insurer fails to provide the detailed explanation required by subsection (2) or subsection (3), the Office of Insurance Regulation shall order the insurer to stop writing new personal injury protection policies in this state until it provides the required explanation.

(5) The sum of \$200,000 of nonrecurring revenue is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation for the purpose of implementing the requirements of subsection (1) during the 2011-2012 fiscal year. Any unexpended balance of the appropriation at the end of the fiscal year shall be carried forward and be available for expenditure during the 2012-2013 fiscal year. Notwithstanding s. 287.057, Florida Statutes, the office may retain an independent consultant to implement the requirements of subsection (1) without a competitive solicitation.

(6) This section shall take effect upon this act becoming a law.

Section 16. The Office of Insurance Regulation shall perform a comprehensive personal injury protection data call and publish the results by January 1, 2015. It is the intent of the Legislature that the office design the data call with the expectation that the Legislature will use the data to help evaluate market conditions relating to the Florida Motor Vehicle No-Fault Law and the impact on the market of reforms to the law made by this act. The elements of the data call must address, but need not be limited to, the following components of the Florida Motor Vehicle No-Fault Law:

- (1) Quantity of personal injury protection claims.
- (2) Type or nature of claimants.
- (3) Amount and type of personal injury protection benefits paid and expenses incurred.

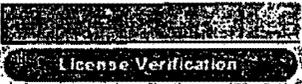
- (4) Type and quantity of, and charges for, medical benefits.
- (5) Attorney fees related to bringing and defending actions for benefits.
- (6) Direct earned premiums for personal injury protection coverage, pure loss ratios, pure premiums, and other information related to premiums and losses.
- (7) Licensed drivers and accidents.
- (8) Fraud and enforcement.

Section 17. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 18. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2012.

Approved by the Governor May 4, 2012.

Filed in Office Secretary of State May 4, 2012.



License Verification

Data As Of 11/17/2012

ROBIN ANDREW MYERS

LICENSE NUMBER: AP1901

Printer Friendly Version

General Information	Secondary Locations
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Profession	
LICENSED ACUPUNCTURIST	
License/Activity Status	
CLEAR/ACTIVE	
License Expiration Date	License Original Issue Date
2/28/2014	12/17/2003
Discipline on File	Public Complaint
NO	NO
Address of Record	
14802 WINDING CREEK COURT TAMPA, FL 33613 UNITED STATES	

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

License Verification

Data As Of 11/18/2012



License Verification

Practitioner Profile

GREGORY STEFEN ZWIRN

LICENSE NUMBER: CH8294

Printer Friendly Version

General Information	Secondary Locations	Practitioner Profile	Subordinate Practitioners
Profession CHIROPRACTIC PHYSICIAN			
License/Activity Status CLEAR/ACTIVE			
License Expiration Date 3/31/2014		License Original Issue Date 07/16/2001	
Discipline on File NO		Public Complaint NO	
Address of Record 4015 N. ARMENIA AVENUE TAMPA, FL 33607			

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License Verification

Date As Of 11/18/2012

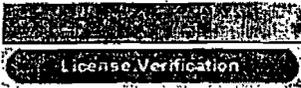
SHERRY LYNN SMITH

LICENSE NUMBER: MA3747

Printer Friendly Version

General Information	Secondary Locations
Profession MESSAGE THERAPIST	
License/Activity Status CLEAR/ACTIVE	
License Expiration Date 8/31/2013	License Original Issue Date 01/28/1981
Discipline on File NO	Public Complaint NO
Address of Record HEALTH, NATURALLY 2831 RINGLING BLVD, STE D114 SARASOTA, FL 34237-5352 UNITED STATES ATTN: SHERRY SMITH, LMT	

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License Verification

Data As Of: 11/17/2012

CARRIE C DAMASKA
LICENSE NUMBER: MA32716

Printer Friendly Version



Profession

MASSAGE THERAPIST

License/Activity Status

CLEAR/ACTIVE

License Expiration Date

8/31/2013

License Original Issue Date

02/08/2001

Discipline on File

NO

Public Complaint

NO

Address of Record

3115 W COLUMBUS DRIVE
SUITE 109
TAMPA, FL 33607
UNITED STATES

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The Florida Senate

Issue Brief 2012-203

August 2011

Committee on Banking and Insurance

PERSONAL INJURY PROTECTION (PIP)

Statement of the Issue

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.

Recently, Florida has experienced an increase in motor vehicle related insurance fraud and the costs associated with PIP coverage. In the 2011 Legislative Session, a number of bills were offered that contained various proposals that sought to address the rising costs in the PIP system. This issue brief outlines the current PIP system, recent trends in PIP fraud, recent trends in PIP costs on a statewide and a regional basis, and relevant legislative proposals offered during the 2011 session.

Discussion

History of the No-fault Law in Florida

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan which took effect January 1, 1972.¹ The no-fault plan was offered as a replacement for the tort reparations system, with the purpose of serving as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault. The proponents of no-fault insurance promoted it as a more efficient and fair means of providing redress to automobile accident victims. They believed that this system provides compensation in a swifter fashion than the tort system, and that no-fault would lower the cost of insurance, with both benefits being primarily produced by reducing litigation. The principle underlying no-fault automobile insurance laws is a trade-off of one benefit for another, by assuring payment of medical, disability (wage loss) and death benefits, regardless of fault, in return for a limitation on the right to sue for non-economic damages (pain and suffering).

The objectives of the no-fault law were enumerated by the Florida Supreme Court in 1974 in *Lasky v. State Farm Insurance Company*². The Court opined that the no-fault law was intended to:

- assure that persons injured in vehicular accidents would be directly compensated by their own insurer, even if the injured party was at fault, thus avoiding dire financial circumstances with the "possibility of swelling the public relief rolls;"
- lessen court congestion and delays in court calendars by limiting the number of law suits;
- lower automobile insurance premiums; and
- end the inequities of recovery under the traditional tort system.

In the ensuing 40 years, the Legislature has periodically revised the no-fault law, courts have interpreted its key provisions, and various constituent groups have analyzed its impact upon Florida motorists. More recently, in Special Session A of the 2003 Legislative Session, a sunset provision was passed that, effective October 1, 2007, repealed the Motor Vehicle No-Fault Law unless the Legislature re-enacted the law prior to such date. While the sunset provision actually did take effect on October 1, 2007, the Legislature re-enacted the no-fault law, effective

¹ The Florida Automobile Reparations Reform Act, known generally as the "nofault law," was passed by the Florida Legislature on June 4, 1971, and became law effective January 1, 1972. Chapter 71-252, L.O.F. The legislature amended the name to "The Florida Motor Vehicle No-Fault Law" in 1982. Chapter 82-243. L.O.F.

² *Lasky v. State Farm Ins. Co.*, 296 So.2d 9, 14 (Fla. 1974).

January 1, 2008, with several changes (including use of fee schedules for some services) designed to help control medical costs.

Current Provisions of Florida's No-fault Law

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and noneconomic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of \$10,000 for bodily injury to any one person and \$20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income and 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a \$10,000 minimum benefit. A \$5,000 death benefit is also provided.

When the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law in 2007,³ the re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to \$10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals; or
- Licensed health care clinics that are accredited by a specified accrediting organization.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B; and,
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer

³ Sections 627.730-627.7405, F.S., effective January 1, 2008.

limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP co-insurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled *Florida's Motor Vehicle No-Fault Law*, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud (Division)⁴ during the three fiscal years beginning in 2002 and ending in 2005.

More recently, the Division has reported even greater increases in the number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. As a significant subset of the overall fraud referrals, the number of staged motor vehicle accidents received by the Division nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). Florida led the nation in staged motor vehicle accident "questionable claims"⁵ from 2007-2009, according to the National Insurance Crime Bureau (NICB).⁶

Representatives from the Division have identified the following factors as contributing to the magnitude of Florida's motor vehicle insurance fraud problem:

- Ease of health care clinic ownership.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services. Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

OIR Personal Injury Protection Data Call

On April 11, 2011, the Office of Insurance Regulation (OIR) issued its *Report on Review of the 2011 Personal Injury Protection Data Call*.⁷ In describing the scope of its Data Call, OIR stated:

Thirty-one companies participated in the Data Call, which covered a scope period from 2006-2010. Twenty-five of those companies represent 80.1% of the market place based on 2009 Total Private Passenger Auto No-Fault Premiums reported to the NAIC. The claim data is based on the date the claim was opened or recorded on the company's system. Closed Claim data is based on the date the claim was closed regardless of when it was opened or recorded.

The data submitted was checked for data integrity, however, the information in this report is based upon the information as received and no audit of the data has been performed.

OIR collected and compiled the data on both a statewide and a regional level basis. Additionally, OIR obtained data from Mitchell International, Inc. ("Mitchell"), which it described as follows:

As a provider of Property & Casualty claims technology solutions, Mitchell International, Inc. ("Mitchell") processes over 50 million transactions annually for over 300 insurance companies. Mitchell has at least 62 customers in the auto insurance market that utilize their medical claims software, DecisionPoint. Mitchell supplied data to the Office which provided a high level review of national trends and the experience here in Florida. The results show that Florida is above the national average in many instances, including provider charges per claim and the average number of procedures per claim.

⁴ The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.

⁵ The NICB defines a "questionable claim" as one in which indications of behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.

⁶ The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies.

⁷ A full copy of the report can be obtained from http://www.flair.com/siteDocuments/PIP_04-08-2011.pdf, last visited on August 11, 2011.

Accordingly, the OIR report contains compilations of data on a national basis, a Florida statewide basis, and on a regional basis. Some of the significant trend comparisons revealed by the report are as follows:

Statewide Data

- The number of licensed drivers in Florida has remained relatively constant between 2004 and 2011, and actually decreased by 0.5% from January 1, 2008 and January 1, 2011.
- The number of crashes in Florida decreased by 8% between 2007 and 2009, and the number of crashes with injuries decreased by 7.3% between 2007 and 2009.
- Notwithstanding the decreasing trend in the number of drivers, the number of crashes, and the number of injuries, the number of PIP claims that were opened in Florida increased by 35.7% from 2008 to 2010.
- Total PIP payments made by insurers increased by 70% between calendar years 2008 and 2010.
- The number of PIP claims that were closed with payment increased by 59.4% between calendar years 2008 and 2010.
- The number of PIP-related lawsuits that were settled increased by 153.3% between calendar years 2008 and 2010.

Regional Data

- In 2010, twenty-seven percent of the state's licensed drivers were in South Florida, while 55% of the state's PIP benefits were paid in South Florida.
- While the percentage of total claims opened in a particular region remained relatively constant for all regions for the period 2006 to 2008, the percentage increase in the number of claims opened by region for the period 2008 to 2010 was: South Florida 55%; Tampa, St. Pete 33%; Southwest Florida 31%; Central Florida 23%; Northeast Florida 15%.
- The number of total PIP payments also remained relatively constant for all regions for the period 2006 to 2008, but the percentage increase in total PIP payments by region for the period 2008 to 2010 was: South Florida 88%; Tampa, St. Pete 55%; Southwest Florida 41%; Central Florida 28%; Northeast Florida 13%.

Florida Compared to National Data

- In 2010, the average number of provider procedures per claim in Florida was 101.7, while the national average (without Florida) was only 47. The average number of procedures per claim in Florida increased from 67.3 in 2007 to its current 2010 level of 101.7.
- In 2010, the average level of provider charges per claim in Florida was \$12,539, while the national average (without Florida) was only \$8,022.

Affordability/PIP Premium Increases

The premiums that an automobile insurance carrier is authorized to charge are governed under s. 627.0651, F.S., which specifies that OIR must consider “[p]ast and prospective loss experience” when establishing a carrier’s authorized rates. Accordingly, as the claim costs for PIP continue to rise, those increases will necessarily drive a corresponding increase in the premiums that must be paid by Florida’s insurance consumers. Not surprisingly, then, recent premium trends are following the same pattern of increase as the claim costs.

At the August 16, 2011, Cabinet meeting, Insurance Commissioner Kevin McCarty presented rate increase data for the top 5 automobile insurance insurers. The 5 insurers represented 42.5% of the automobile insurance market, and the data presented the amount of rate increase that had been implemented from January 1, 2009 and August 1, 2011. Over this period, the 5 insurers implemented respective average PIP increases of: State Farm Mutual Automobile Insurance Company 49.7%; GEICO General Insurance Company 72.2%; Progressive American Insurance Company 63.0%; Progressive Select Insurance Company 48.5%; Allstate Insurance Company 35.1%.

Representatives of OIR anticipate this trend will continue under the current circumstances.

2011 Proposed Legislation

During the 2011 Legislative Session, proposals seeking to address some of the elements raised in this brief were discussed and debated as the subject of several bills that did not pass.⁸ Some of the proposals went through more than one iteration and were contained in more than one bill, covering major topics that include:

1. Limiting the plaintiff's attorney fees in a no-fault dispute to the lesser of \$10,000 or three times the amount recovered, with a class action limit of the lesser of \$50,000 or three times the recovery.

Proponents of this provision argue that often an award of attorney fees can be excessive, even when the actual damage suffered by the PIP plaintiff is nominal, thus defying the central purpose of a no-fault system that was designed to be self-effecting in order to avoid high legal costs associated with an at-fault system. Opponents argue that often the only way for a plaintiff to obtain legal representation to sue an intransigent insurer is to allow full recovery of the plaintiff's legal fees.

2. Prohibiting the use of a contingency risk multiplier to calculate the attorney's fees recovered under the no-fault law.

Proponents of this provision argue that the purpose of a contingency risk multiplier is to encourage an attorney to be willing to take a high risk case of particular complexity, but the multiplier is often awarded in simple PIP claims of nominal levels -- circumstances that do not reflect the intent of using a multiplier. Opponents argue that PIP claims often involve very complex issues, in spite of the low claim value, and that courts seldom apply the multiplier under current law.

3. Authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider, and with the provision that the insured forfeits the premium discount upon using a non-network provider for non-emergency services if there are qualified network providers within 15 miles of the insured's residence. Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" (PPO) option, but if the insured uses an "out-of-network" provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law.

Proponents of this provision argue that this would allow the consumer to choose whether to buy a less expensive product that has some restriction on the provider network that is available after an accident, or to buy a more expensive product that has no provider restriction after an accident. Opponents argue that consumers could be induced by low premiums to buy a product that would not meet their medical needs after an accident.

4. Authorizing insurers to offer motor vehicle insurance policies that allow the insurer or claimant to demand arbitration of claims disputes over PIP benefits.

Proponents of this provision argue that this would allow for a more expeditious and inexpensive process for the resolution of PIP disputes. Opponents argue that often the controversy in question is of a legal nature, which does not lend itself to proper resolution through the arbitration process.

5. Revising several provisions related to demand letters:
 - The claimant filing suit must submit the demand letter.
 - A demand letter that does not meet the statutory requirements is defective.
 - A demand letter cannot be used to request record production from the insurer.
 - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect.

⁸ See: SB 1694 by Senator Richter; SB 1930 by Senator Bogdanoff; HB 967 by Representatives Horner and Boyd; and HB 1411 by Representative Boyd.

Proponents of these provisions argue that requiring greater specificity to perfect a demand letter would better able insurers to obtain the level of detail necessary to make an informed decision on whether to dispute the claim. Opponents argue that this is unnecessary because an insurer can refuse to pay a demand when a demand letter does not justify payment, requiring the claimant to sue, whereby the insurer would be able to obtain detailed information through discovery.

6. Requiring the insured and any medical provider that accepts an assignment of no-fault benefits from the insured to comply with all terms of the policy, including submitting to an examination under oath (EUO).

Medical providers and insurers dispute whether a medical provider who has accepted an assignment of benefits may be required by the insurer to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,⁹ that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. Proponents argue that often only the medical provider has the expertise to answer the questions necessary to determine whether the full amount of a claim should be paid, and when the provider is assigned benefits, that provider should be required to adhere to the contractual obligation to submit to an EUO. Opponents argue that the information necessary to determine payment is already available to the insurer through medical documentation, and that this provision, as proposed, could be abused by insurers to harass and unduly encroach on the time that a provider could be spending to treat patients.

7. Clarifying that the Medicare fee schedule in effect of January 1 of a given year will be the schedule that controls throughout that year for determining the proper PIP fee schedule to be applied for an accident that occurs during that calendar year.

Currently, Section 627.736(5), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to a specified percentage of the Medicare schedule, with variations depending on the specific medical service rendered. The payments cannot go below the 2007 Medicare levels, but the payments are to reflect any increases that have been made to the 2007 Medicare levels. Insurers state that because Medicare changes its schedule periodically throughout the year, there is often confusion as to the proper Medicare fee schedule to apply, resulting in unintended disputes over minor differences. Proponents believe this confusion will be relieved by tying the PIP payment to the Medicare fee schedule in effect as of January 1 of a given year (not to go below the 2007 Medicare schedule).

8. Prohibiting a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act.

Insurers believe this provision would be a significant deterrent to claimants who otherwise might contemplate submitting false or misleading information. Opponents are concerned about the possibility of extreme consequences when the claimant unintentionally submits questionable information.

9. Increasing the civil penalties (fines) that can be levied on perpetrators of insurance fraud, and requiring suspension of an occupational license or a health care practitioner license for any person convicted of insurance fraud.

Proponents argue that these provisions will be a further deterrent to individuals who otherwise contemplate committing acts of insurance fraud. Opponents have expressed some concern over the implementation of some of the provisions that were proposed.

10. Creating a rebuttable presumption that the injured party's failure to appear for a mental or physical examination was unreasonable.

⁹ *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Insurers have complained that they are often stymied by claimants' continued failure to appear for the examination that the insurer must conduct to determine whether they dispute the claim in question. Opponents fear that, unless qualified, this provision could be abused by insurers to establish an inconvenient time that the claimant would not be able to attend.

11. Authorizing an insurer to conduct an on-site physical review and examination of the treatment location.

Proponents of this provision argue that this would allow an insurer to ascertain that a clinic or other treatment facility actually possessed the equipment (MRI, X-ray, etc.) necessary to perform the testing and treatment being claimed, and to expose sham facilities. Opponents fear that this provision, unless qualified, could be abused by an insurer to intimidate or inconvenience legitimate operations.

12. Prohibiting a claimant from filing a lawsuit until the claimant complies with the insurer's investigation.

Proponents of this provision argue that this provision would help to resolve those cases where there ultimately is no dispute, before expensive litigation costs are added into the equation. Opponents believe this provision would be abused by some insurers to draw out the process and avoid paying legitimate claims.

ATTACHMENT 3

**IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, STATE OF FLORIDA
CIVIL DIVISION**

**ROBIN A. MYERS, A.P., an individual person
and Acupuncture Physician, GREGORY S.
ZWIRN, D.C., an individual person and
Chiropractic Physician, SHERRY L . SMITH, L.M.T.,
an individual person and Licensed Massage Therapist,
CARRIE C. DAMASKA, L.M.T., an individual
person and Licensed Massage Therapist, "John Doe,"
on behalf of all similarly situated health care providers,
and "Jane Doe," on behalf of all those individuals
injured by motor vehicle collisions,**

Plaintiffs,

Case: 2013-CA-000073

v.

**KEVIN N. McCARTY, in his Official Capacity as
Commissioner of the Florida Office of Insurance
Regulation,**

Defendant.

**PLAINTIFFS' MOTION FOR TEMPORARY INJUNCTION
WITH INCORPORATED MEMORANDUM OF LAW IN SUPPORT THEREOF**

PLAINTIFFS, by and through the undersigned counsel Plaintiffs, in the cases captioned above, by and through their undersigned attorneys, and pursuant to Section 26.012 (3), F.S., 2012 and to Rule 1.610, Fla.R.Civ.P., respectfully move this Court for the entry of a Temporary Injunction enjoining the Defendant, Office of Insurance Regulation, and all those acting in concert with or at the behest of Defendant, from enforcing, or attempting to enforce the 2012 PIP Act, as described below. In support thereof, Plaintiffs state as follows:

I. INTRODUCTION & BASIS FOR EMERGENCY AND EXTRAORDINARY RELIEF

Plaintiffs filed a complaint challenging the constitutionality of the 2012 PIP Act (Florida Statutes Chapter 2012-197) because the 2012 PIP Act adversely affects each individual Plaintiff, causing each to suffer irreparable harm, with no adequate remedy at law. This action seeks, through temporary and permanent injunction, to prevent the irreparable harm described herein and other damages resulting from the dramatic limitations and deprivations that the 2012 PIP Act will cause both to Plaintiffs, as well as Florida's healthcare providers and healthcare consumers.

Pursuant to §26.012(3), Fla. Stat. (2012), and Rule 1.610, Fla. R. Civ. Pro., this Court is authorized to enter an order for temporary injunction on behalf of the Plaintiffs. In the absence of such a temporary injunction, Plaintiffs MYERS, ZWIRN, SMITH, DAMASKA, and JOHN DOE will each suffer irreparable harm directly caused by the 2012 PIP Act for which there exist no adequate remedy at law, based on the following:

- (1). Plaintiffs MYERS and JOHN DOE, as Florida licensed Acupuncture Physicians, will no longer be able to provide any insurance related compensable healthcare evaluation and treatment to or for any person injured as a result of a motor vehicle collision;
- (2). Plaintiffs ZWIRN and JOHN DOE, as Florida licensed Chiropractic Physicians, will only be able to provide insurance related compensable healthcare evaluation and treatment to or for any person injured as a result of a motor vehicle collision that comports with that allowed by the United States Centers for Medicare and Medicaid Services (CMS)¹;

¹ The 2012 PIP Act limits coverage provided by Chiropractic Physicians to only those manual spinal manipulations allowed by CMS guidelines and excludes any adjuvant therapies such as electrical stimulation, temperature therapy, or non-spinal manipulation therapy. Further, the 2012 PIP Act limits total benefits to \$2,500.00 if the initial evaluation is by a Chiropractic

(3). Plaintiff s SMITH, DAMASKA and JOHN DOE, as Florida Licensed Massage

Therapists, will no longer be able to provide any insurance related compensable healthcare treatment to or for any person injured as a result of a motor vehicle collision; and

(4). Plaintiff JANE DOE, although required to purchase \$10,000.00 (ten thousand

dollars) in PIP insurance by the Florida Statutes, may receive no benefits if the initial evaluation and treatment does not occur within fourteen (14) days, or may only receive \$2,500.00 in benefits if there is no emergency medical condition diagnosed or if the initial evaluation is by a Chiropractic Physician.

Personal Injury Protection (PIP) Insurance was introduced in Florida in 1971 as a no-fault scheme to provide Floridians injured as a result of motor vehicle collisions with rapid access to third party healthcare payment. PIP insurance was initially challenged because it impermissibly limited access to the courts. However, PIP insurance was ultimately upheld because its accommodation for efficient, unfettered access to healthcare payment constituted a sufficient alternative to court access. *Lasky v. State Farm Insurance Co.*, 296 So. 2d 9 (Fla. 1974).

In a laudable effort to decrease PIP insurance premiums by decreasing PIP insurance fraud, the Florida Legislature proposed a variety of modifications to the PIP statutes leading to the 2012 PIP Act that was signed by Governor Scott on May 4, 2012. In return for broad, sweeping changes to the PIP Statutes, PIP insurers were required by the 2012 PIP Act to decrease PIP insurance premiums. Unfortunately, not only did that not happen, the State actually approved PIP insurance premium rate increases. (Insurers File For PIP Rate Increases, Tia

Physician or if the initial evaluation is by an M.D., D.O., or D.D.S., and no emergency medical condition is diagnosed.

Mitchell, Miami Herald October 10, 2012 last accessed January 6, 2013: <http://www.miamiherald.com/2012/10/01/3029716/insurers-file-for-pip-rate-increases.html>).

Without any evidence or suggestion of fraud prevention and in the absence of any peer-reviewed, published medical literature contesting the validity or benefit of Acupuncture, Massage Therapy, or Chiropractic, the 2012 PIP Act alters four (4) separate titles of the Florida Statutes including those for Motor Vehicles, Public Health, Insurance, and Crimes by amending ten (10) distinct sections of the Florida Statutes and creating two (2) new sections and absolutely prohibits any further compensation for either Acupuncture or Massage Therapy and severely limits Chiropractic care.

Defendant's argument that Plaintiffs seek to reinstate statutorily defined rights related to PIP insurance conflates unrelated issues. Plaintiffs agree that PIP and PIP insurance are created by statute. Plaintiffs take issue with the fact that the 2012 PIP Act excludes them from any compensation when PIP is merely another third party payor for healthcare services. During PIP's statutory creation and initial legal defense, PIP was meant to provide unfettered, efficient access to healthcare – like any other third party payor. Because purchase of PIP insurance is mandated by state statute, and because PIP insurance provides the sole form of compensation for evaluating and treating motor vehicle collision victims, Plaintiffs' unilateral exclusion from PIP insurance compensation is unfair, and unjust; especially when Plaintiffs historically provided such care – more so than many that were included. How many times do those injured in motor vehicle collisions with back pain actually seek primary dental evaluation?

II. PLAINTIFFS ARE ENTITLED TO A TEMPORARY INJUNCTION

A temporary injunction should be granted in this case because the 2012 PIP Act is facially unconstitutional and to prevent irreparable harm to each of the Plaintiffs because there

exists no adequate remedy at law, because the Plaintiffs are likely to succeed on the merits of their claims, because the threatened injury to the Plaintiffs outweighs any possible harm to the Defendant, and because the granting of a temporary injunction will support the public interest.

The 2012 PIP Act is facially unconstitutional because it: It violates the “single subject rule” required by the Florida Constitution; It contains a variety of restrictions and limitations that the separation of powers doctrine; In the absence of either a compelling governmental interest or rational basis, it violates due process of law; It constitutes an improper taking where, once granted, professional licensure becomes a vested property right; It violates equal protection, also in the absence of a compelling governmental interest or rational basis; It is based on unsupported, unpublished statistical assumptions that were not the product of proper research methodology; It unduly limits the rights of both medical professionals and consumers; It totally voids the sufficient alternative relied upon by the courts to allow the original no-fault PIP insurance scheme to limit Floridian’s access to the courts;

Temporary injunctions require that the trial court “determine that the petition or pleadings demonstrate a *prima facie*, clear legal right to the relief requested. *SunTrust Banks, Inc. v. Cauthon & McGuigan, PLC*, 78 So. 3d 709, 711 (Fla. 1st DCA 2012) quoting *St. Johns Inv. Mgmt. Co. v. Albaneze*, 22 So. 3d 728, 731 (Fla. 1st DCA 2009)

To demonstrate a *prima facie* case for temporary injunction, the petitioner must establish four factors: (1) the likelihood of irreparable harm; (2) the unavailability of an adequate remedy at law; (3) a substantial likelihood of success on the merits; and (4) that a temporary injunction would serve the public interest.

Id.

As detailed below, Plaintiffs will suffer and are presently suffering irreparable harm. Additionally, please also refer to the separately filed affidavits and included testimony summary

that constitute a representative cross section of Florida Licensed, practicing Acupuncture Physicians, Licensed Massage Therapists, and Chiropractic Physicians. In addition to the averments made by the named Plaintiffs, these affidavits on behalf of Plaintiff JOHN DOE and Plaintiff JANE DOE clearly demonstrate that a temporary injunction is necessary to prevent irreparable harm for which there exist no adequate remedy at law, that there exist a substantial likelihood of success given the 2012 PIP Acts unconstitutionality, and that a temporary injunction will best serve the public interest by maintaining the *status quo* and protecting the health, safety, and well being of Florida's citizens.

A. Plaintiffs' Likelihood of Irreparable Harm

Plaintiffs will suffer irreparable harm because the 2012 PIP Act will either cause them not to be able to work and earn a living (Acupuncture Physicians and Licensed Massage Therapists) or will severely restrain their ability to provide effective care (Chiropractors). Effective January 1, 2013, unless a Temporary Injunction is ordered, no effort to mitigate the Plaintiffs' resulting damages or irreparable harm can possibly be successful because the 2012 PIP Act absolutely prevents all Acupuncture Physicians from providing any reimbursable medical care to all Florida citizens injured during motor vehicle collisions covered by PIP insurance.

Acupuncture Physicians primarily treating motor vehicle accident victims will no longer be compensated to provide care and will be forced to close or limit their businesses. Similarly, the 2012 PIP Act absolutely prevents all Licensed Massage from providing any reimbursable medical care to all Florida citizens injured during motor vehicle collisions covered by PIP insurance. Licensed Massage Therapists primarily treating motor vehicle accident victims will no longer be compensated to provide care and will be forced to close or limit their businesses.

The 2012 PIP Act Dramatically reduces Chiropractic care by seventy five percent (75%) because PIP insurance coverage will be limited to \$2,500 (two thousand five hundred dollars) in the absence of an emergency medical condition – despite citizens being required to purchase \$10,000 (ten thousand dollars) of PIP insurance coverage. Further, although historically Chiropractors evaluated and treated those injured by motor vehicle collisions, under the 2012 PIP Act, Chiropractors may not diagnose emergency medical conditions; this is left to Medical Doctors, Osteopathic Doctors, Dentists, and other healthcare extenders like Physician’s Assistants. Chiropractic Physicians primarily treating motor vehicle accident victims will no longer be compensated to provide care and will be forced to close or limit their businesses.

The 2012 PIP Act manifests a clear and present danger to the continued operations of the Plaintiffs’ businesses and livelihoods resulting in an irreparable harm that vastly exceeds any monetary compensation. The most egregious form of the irreparable harm caused by the 2012 PIP Act is found in the loss of the Plaintiffs’ constitutional rights and freedoms manifest by their livelihoods and businesses. These rights and freedoms include, generally, the right to due process of law, the right to equal protection of the law, and the right to earn a living and enjoy the fruits of one’s labors, as well as the ownership and use of private property without undue governmental interference.

Plaintiffs averred that each, “began losing business and suffering economic damages and non-economic damages in the form of good will and healthcare provider-patient relationships after the 2012 PIP Act was enacted.” Complaint ¶5. Further, Plaintiffs averred that they, “are presently experiencing irreparable harm(s) suffered by their elimination or drastic restriction from being able to provide healthcare to those injured as a result of motor vehicle collisions. Complaint ¶7.

Accordingly, Plaintiffs may not mitigate their damages without a temporary injunction. If the 2012 PIP Act is permitted to become effective on January 1, 2013, Plaintiff Myers, Plaintiff Smith, Plaintiff Damaska, Plaintiff John Doe Acupuncture Physician, and Plaintiff John Doe Licensed Massage Therapist will all lose a significant amount of their ability to work and earn a living. Such a significant loss of work will rapidly result in a devastating downwards financial spiral that will result in the permanent loss of their businesses and business relationships and good will. Plaintiffs possess no adequate remedy at law because there is no plain, certain, prompt, speedy, sufficient, complete, practical, or efficient way to attain the ends of justice without *immediately* enjoining the enforcement of this challenged legislation.

B. Unavailability of Adequate Remedy at Law

Plaintiffs possess no adequate remedy at law because no amount of monetary damages may adequately compensate them for the irreparable harm they are now suffering including the loss or deprivation of their constitutional rights. Complaint ¶8. The loss of any constitutional right or freedom, in and of itself, constitutes irreparable harm. See *Tampa Sports Authority v. Johnston*, 914 So.2d 1076 (Fla. 2d DCA 2005).

Even more importantly, the loss of customers, loss of business goodwill and the threats to a business' vitality all represent irreparable harm justifying injunctive relief. Plaintiffs fear not just the loss of business, but they also fear of the loss of business goodwill and the loss of the ability to continue to engage in a lawful enterprise and enjoy the fruits of one's enterprise without undue governmental interference and attack. Fear of enforcement has already resulted in a loss of employee morale and customer confidence. Plaintiffs are suffering irreparable harm from declinations in the type of treatment they are allowed to provide their patients, and the extent of such care.

The Florida Statutes require that all Floridians with motor vehicles purchase a minimum of \$10,000.00 (ten thousand dollars) in PIP insurance coverage. Despite this required purchase, the 2012 PIP Act eliminates any coverage if none is sought within an arbitrarily defined fourteen (14) day post-collision window. There exist no data to support the supposition that a person is absolutely not injured if they are not evaluated within fourteen (14) days of a motor vehicle collision. Indeed, some injuries may actually arise after this fourteen (14) day window. The previous limitations related to efficient, unfettered access to healthcare here is dramatically limited without any supporting data.

Further, if an injured person should seek evaluation by an M.D., a D.O., or a D.D.S. within fourteen (14) days, that person will only receive \$2,500.00 (two thousand five hundred dollars) in coverage unless they are diagnosed with an emergency medical condition. Unfortunately, the definitions for emergency medical condition are equally lacking and are not supported by peer-reviewed, best medical practices. In all cases, if a chiropractic physician should initially evaluate an injured patient, that patient will only receive a total of \$2,500.00 (two thousand five hundred) dollars in coverage.

It remains completely mysterious as to how a D.D.S. somehow became more familiar with motor vehicle collisions and emergency medical conditions than state-licensed Chiropractic Physicians who were already providing this kind of evaluation and care for the past several decades. Dramatically limiting or eliminating the amount of PIP insurance coverage available limits the unfettered efficient access to healthcare originally intended without providing any remedy at law.

C. Plaintiffs' Likelihood of Success on the Merits

Plaintiffs will likely succeed on the merits of their claim. Plaintiffs' Verified Complaint, asserted as the equivalent of Supporting Affidavits, offers *prima facie* proof that Plaintiffs possess a substantial likelihood of success on the merits of this action because Plaintiffs unequivocally prove that enforcement of the 2012 PIP Act impermissibly denies or abrogates Plaintiffs' constitutional rights including: 1) Plaintiffs' right to work; 2) Plaintiffs' right of access to the courts; 3) Plaintiffs' right to equal protection; and 4) Plaintiffs' right to due process.

On its face, the 2012 PIP Act provisions are arbitrary, oppressive and capricious and represent an unlawful exercise of Florida's police power because there exist no substantial relationship to the protection of the public health and welfare, or to any legitimate governmental objective, and the provisions of the 2012 PIP Act. On its face, the 2012 PIP Act violates both single subject rule for state statutes, and the separation of powers doctrine by blending criminal, civil, and administrative penalties; by imposing inconsistent and unnecessary regulations conflicting with existing statutes and regulations; and by impermissibly limiting damages an injured party may obtain. Unfortunately, the 2012 PIP Act provisions are specifically and narrowly defined to protect certain private business (PIP insurance carriers) to the detriment of other private businesses and Florida's citizens at large.

An injunctive remedy is appropriate, on proper showing of injury, to *restrain the enforcement of an invalid law*. *Daniel v. Williams*, 189 So. 2d 640 (Fla. Dist. Ct. App. 2d Dist. 1966); *Board of Com'rs of State Institutions v. Tallahassee Bank & Trust Co.*, 100 So. 2d 67 (Fla. Dist. Ct. App. 1st Dist. 1958). The injury may consist of the infringement of a property right. See *Louisville & N.R. Co. v. Railroad Com'rs*, 63 Fla. 491, 58 So. 543 (1912). It may also exist in the right to earn a livelihood and continue practicing one's employment. *Watson v. Centro Espanol De Tampa*, 158 Fla. 796, 30 So. 2d 288 (1947). Persons who are the subject of

harassment by overzealous, improper, or bad-faith use of valid statutes may be afforded the protection of injunctive relief. *Kimball v. Florida Dept. of Health and Rehabilitative Services*, 682 So. 2d 637 (Fla. Dist. Ct. App. 2d Dist. 1996).

Enforcement of the 2012 PIP Act manifests all the components of an invalid law because it abrogates the Plaintiffs' rights to due process and equal protection and because operation of this law will absolutely prohibit the Plaintiffs from continuing to provide either Acupuncture or Massage Therapy (but only for victims of motor vehicle accidents), and will dramatically limit and restrain the Plaintiffs from providing Chiropractic care for motor vehicle accident victims, but only if that Chiropractic care is not certified by a Medical Doctor, an Osteopathic Doctor, or a Dentist, but not a Chiropractor.

Finally, enforcement of the 2012 PIP Act represents an invalid taking because once the state licenses a healthcare provider, that provider possesses a property right in his license. The 2012 PIP Act impermissibly denies or limits those already possessing licenses the ability to earn a living or provide healthcare to those in need. For these reasons, the Plaintiffs are likely to succeed on the merits of their claim.

Plaintiffs are substantially likely to succeed on the merits because the 2012 PIP Act: clearly violates the single subject rule, is arbitrary and capricious, denies due process by imposing strict liability for innocent business activities, represents an unlawful exercise of the state's police power because there exist no substantial relationship to the protection of the public health and welfare or any legitimate governmental objective save perhaps only benefiting PIP insurance carriers, denies due process by imposing inconsistent and unnecessary regulations conflicting with existent state statutes and by imposing strict liability, and because the 2012 PIP

Act appears specifically designed to protect the PIP insurance industry while compromising the rights and protections afforded to Floridians by the Constitution of the State of Florida.

D. A Temporary Injunction Will Serve the Public Interest

The 2012 PIP Act only benefits PIP Insurers – in addition to the fact that the promised reductions in PIP premiums never materialized, PIP insurance premiums have actually risen and PIP insureds now actually possess less coverage as a result of an emergency rule making permitting PIP insurers to unilaterally re-write PIP insurance coverage contracts.

The *status quo* should be maintained until this case reaches trial to protect the health, safety, and well being of all Floridians. The 2012 PIP Act dramatically changes the manner that each and every person injured as a result of a motor vehicle injury is evaluated and treated without providing any peer-reviewed or best-practices medical evidence that either the current system is medically flawed or that the new, improved system will benefit patients. Maintaining the *status quo* by temporary injunction allows the continued protection of the health, safety, and well being of all Floridians injured as a motor vehicle collision, in the same manner that has developed over the past few decades, while continuing to promote the unfettered access to efficient care that was traded in return for limiting Floridian's access to the courts.

Here, the *status quo* also means that Plaintiffs will be allowed to continue in their lawful medical and business practices, pursuant to the licenses already granted them by the State of Florida – the very State seeking to terminate or severely limit their ability to earn a living. Plaintiffs should be allowed to continue to provide and, in the case of Jane Doe, receive necessary medical evaluation and treatment for the injuries sustained during motor vehicle collisions before the wholesale elimination of valuable treatment modalities and the imposition of arbitrary limitations by a legislative body with few if any licensed healthcare providers.

Plaintiffs' other constitutional rights and the maintenance of the status quo require the issuance temporary injunction:

The status quo preserved by a temporary injunction is the last peaceable non-contested condition that preceded the controversy, *Bowling v. National Convoy & Trucking Co.*, 135 So. 541 (Fla. 1931). One critical purpose of temporary injunctions is to prevent injury so that a party will not be forced to seek redress for damages after they have occurred.

Lewis v. Peters, 66 So.2d 489 (Fla. 1953) See also *Bailey v. Christo*, 453 So.2d 1134 (Fla. 1st DCA 1984).

In the instant action, the last "peaceable non-contested condition" that preceded this controversy was that these medical professionals were operating, lawfully, and enjoying their rights to engage in the lawful provision of medical treatment to patients with PIP coverage, enjoying both their business and property rights and the fruits of their industry. Obviously, no such status quo would give any Plaintiffs the right to violate any other existing statutes. The status quo should be preserved by the issuance of a temporary Injunction.

Granting a Temporary Injunction and maintaining the *status quo* will not result in a disservice the public interest because the public interest is best served by protecting the rights and privileges afforded by the Florida Constitution and because the public interest is best served by protecting the health, safety, and well being of its citizens. Although the Legislature's intent to prevent insurance fraud was laudable, the provisions of the 2012 PIP Act reduce the care provided to motor vehicle accident victims by reducing Chiropractic care by seventy five percent (75%) and by eliminating all care provided by Licensed Massage Therapists and Acupuncture Physicians without any evidence that these draconian measures will in fact reduce PIP insurance fraud.

Florida provided no data to suggest or prove that eliminating all Acupuncture care for motor vehicle accident victims, but not for any other injury victims, would improve the health, safety and wellbeing of its citizens. Equally, Florida provided no data to suggest or prove that the Acupuncture care currently being provided by Acupuncture Physicians licensed by the State of Florida to motor vehicle accident victims endangered their health, safety, or wellbeing. Florida provided no data to suggest or prove that severely limiting Chiropractic care for motor vehicle accident victims, but not for any other injury victims, would improve the health, safety and wellbeing of its citizens. Equally, Florida provided no data to suggest or prove that the Chiropractic care currently being provided by Chiropractic Physicians licensed by the State of Florida to motor vehicle accident victims endangered their health, safety, or wellbeing.

Florida provided no data to suggest or prove that eliminating all Massage Therapy care for motor vehicle accident victims, but not for any other injury victims, would improve the health, safety and wellbeing of its citizens. Equally, Florida provided no data to suggest or prove that the Massage Therapy care currently being provided by Licensed Massage Therapists licensed by the State of Florida to motor vehicle accident victims endangered their health, safety, or wellbeing. Here, a temporary injunction will allow motor vehicle accident victims access to the care they are already receiving and presumably benefiting from – why else would they continue to receive treatment?

The Plaintiffs' rights to enjoy their constitutionally protected rights to conduct their business and enjoy the benefits of their industry, enjoy due process of law, equal protection of the laws, and the numerous other rights articulated in the above sections cannot be lawfully abridged through the enforcement of the PIP Act. The greatest public interest lies in the freedoms and rights to due process guaranteed by the Constitution. Similarly, the public interest is served

by abatement of unconstitutional activity. *Illinois Migrant Council v. Pilliod*, 540 F.2d 1062, 1071, (7th Cir. 1976). See also *DiDomenico v. Employers Cooperative Industry Trust*, 676 F.Supp. 903 (N.D. Ind. 1987) and *Zurn Constructors*, *supra*. The overall public interest is served by safeguarding these Constitutional freedoms and the right to due process. Granting a temporary injunction will serve the public interest by protecting the public's health, safety, and well being while promoting efficient, unfettered access to healthcare following a motor vehicle collision.

E. The Exclusion or Limitation of Some Types of Licensed Healthcare Providers Abrogates Plaintiffs' Rights to Due Process and Such Restrictions are Neither Reasonable Nor Necessary

The right of a properly qualified and licensed healthcare provider to practice a particular branch of the healing arts is a valuable property right in which the healthcare provider is entitled to be protected and secured. *State ex rel. Estep v. Richardson*, 148 Fla. 48, 3 So. 2d 512 (1941). Equally, the preservation and protection of the public health is one of the duties that devolve on the state in the exercise of its inherent police power. See Fla. Jur. 2d, Health and Sanitation § 1.

In the performance and furtherance of this duty, the state has the power, within reasonable constitutional limitations, to control the practice of the healing arts and those who engage in such practice. *Fischwenger v. York*, 154 Fla. 450, 18 So. 2d 8 (1944). Thus, the opportunity to practice medicine and engage as a healthcare provider is not an absolute right but is subject to the well-established police power of the state. *Cohen v. Department of Professional Regulation, Bd. of Medicine*, 590 So. 2d 477 (Fla. Dist. Ct. App. 1st Dist. 1991).

Generally, in regulating professions and occupations, it is the intent of the legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or

damage and that the police power of the state be exercised only to the extent necessary for that purpose. Furthermore, **“it is the legislature's intent that no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public, and that persons desiring to engage in any lawful profession regulated by the Department of Business and Professional Regulation will be entitled to do so as a matter of right, if otherwise qualified.”** Fla. Jur. 2d, Business and Occupations §1. The 2012 PIP Act is arbitrary and capricious because even the Florida Department of Health, responsible for licensing healthcare providers, may not create unreasonably restrictive and extraordinary standards that deter qualified persons from entering the various professions, so the unfair and disparate treatment manifest in the PIP Act is simply arbitrary and capricious.

As set forth in the Complaint, there is simply no statistical basis in any of the materials presented to purportedly support the elimination of various healthcare professions from PIP coverage compensation. Simply stated, the State has an attendant “laundry list “of legislation to deal with “fraud,” regardless of whether it is based on any specific healthcare profession. The least persuasive reason given for the adoption of the PIP Act is that investigations into clinics and various healthcare professions were lengthy, costly, and man-power intensive. Any requirement for “police efficiency” does not justify the adoption of enforcement legislation that puts any Plaintiff out of business. “Expediency, however, is not the test, and we conclude that convenience of enforcement does not warrant the broad restriction imposed by Sec. 370.172(3).” See *State v. Saiez*, 489 So.2d 1125 (Fla. 1986).

Regardless of the litany of unauthenticated statistics, there was no methodologically sound basis to conclude that the healthcare professions of Massage Therapy or Acupuncture lend themselves to more frequent commission of “PIP fraud” than any other profession. Where there is no reasonable identifiable rational relationship between the demands of the public welfare and restraint upon private business, the latter will not be permitted to stand. See *Eskind v. Vero Beach*, 159 So.2d 209 (Fla. 1963). The number of “independent variables” applicable to the increase in PIP claims that were completely overlooked included the explosion of “referral” services saturating every form of media. To ignore just this one inescapable variable casts doubt on any conclusion that the increase in PIP claims is solely related to PIP fraud by all Acupuncture Physicians and all Licensed Massage Therapists.

There is no plausible way to presume that forcing innocent business owners such as the Plaintiffs to close their doors will help solve any problem, and, as before, to catch the operators that are guilty of fraud will require law enforcement resources, without which there would be no benefit or decrease in the presumed “increased insurance premiums,” a goal already debunked by current information, as established by the Florida Office of Insurance Regulation’s own status report.

Critically, the State already possesses more than ample legislation to deal with *any and all* “fraud” that may be involved in the provision of PIP medical treatment. For example, §§ 400.990- 400.995 of the Florida Statutes already contain a comprehensive and thorough administrative framework for the licensing and regulation of Health Care Clinic that include severe administrative penalties, including denial of, suspension of, or revocation of a license, over and above the criminal felony options for healthcare fraud. Based on the extensive

regulatory framework already set forth in the Florida Statutes, any argument that the PIP Act is "necessary" to deal with fraud is not correct.

Plaintiffs possess a clear legal right to the use and operation of their businesses and the provision of licensed health care services, and they are already subject to punishment for any "fraud" related thereto. Title XXIX, the Health Care provisions of the Florida Statutes, Ch. 400, Sec X, dealing with Health Care Clinics (such as those licensed Plaintiffs herein); Title XXXII, including Chapters 456 (health professions), 457 (acupuncture), 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), 462 (naturopathy), 463 (optometry), and 464 (nursing), already provide an even handed way of regulating and policing various medical professions. The PIP Act does not. There are ample statutes that prevent and/or criminalize virtually every valid concern: Ch. 817 (dealing comprehensively with fraud), Title XXXVII, Insurance, Ch. 627, "Motor Vehicle and Casualty Insurance Contracts," all of which are created by the state to comprehensively regulate the field of health care and any "fraud" related thereto.

As a well settled area of law, the state's "police power" to enact laws for the protection of its citizens is confined to those acts which may be reasonably construed as expedient for the protection of the public health, safety, welfare, and morals. *State v. Saiez*, 489 So.2d 1125 (Fla. 1986). Substantive due process is violated, however, when irrational legislative means have been adopted to realize a legislative goal. *State v. Walker*, 444 So.2d 1137 (Fla. 2d DCA 1984), affirmed, 461 So.2d 108 (Fla. 1984).

At least three Florida Supreme Court cases declared Florida statutes unconstitutional on substantive due process grounds. *Schmitt v. State*, 590 So.2d 404, 413 (Fla. 1991); *State v. Walker*, 444 So.2d 1137 (Fla. 2d DCA 1984), aff'd 461 So.2d 108 (Fla. 1984); *State v. Saiez*, 489

So.2d 1125 (Fla. 1986). In *Saiez*, (489 So.2d at 1128) the Court invalidated a statute that prohibited possession of credit card embossing machines under Section 817.63, F.S. (1983). Although the statute had a permissible goal, attempting to curtail credit card fraud, the means chosen, prohibiting possession of the machines, did not bear a rational relationship to that goal. Criminalizing the mere possession of the machines interfered with "the legitimate personal and property rights of a number of individuals who use [them] for non-criminal activities." [*Id.* at 1129]. In other words, the statute criminalized activity that was otherwise inherently innocent.

In *Saiez*, the Court found the statute unconstitutional because it violated substantive due process under the Fourteenth Amendment to the United States Constitution and Article I, Section 9 of the Florida Constitution. The Court stated:

"The due process clauses of our federal and state constitutions establish a 'sphere of personal liberty' for every individual subject only to reasonable intrusion by the state in furtherance of legitimate state interests. See *Del Percio*, 476 So.2d at 202 (quoting from *Richards v. Thurston*, 424 F.2d 1281, 1284 (1st Cir.1970)).

"The legislature enacts penal statutes, such as section 817.63, under the state's 'police power' which derives from the state's sovereign right to enact laws for the protection of its citizens. See *Carroll v. State*, 361 So.2d 144, 146 (Fla.1978). Such power, however, is not boundless and is confined to those acts which may be reasonably construed as expedient for protection of the public health, safety, welfare, or morals. *Hamilton v. State*, 366 So.2d 8, 10 (Fla.1978); *Newman v. Carson*, 280 So.2d 426, 428 (Fla.1973). The due process clauses of our federal and state constitutions do not prevent the legitimate interference with individual rights under the police power, but do place limits on such interference. *State v. Leone*, 118 So.2d 781, 784 (Fla.1960). See also *Coca-Cola Co., Food Division v. State, Department of Citrus*, 406 So.2d 1079, 1084-85 (Fla.1981), *appeal dismissed sub nom. Kraft, Inc. v. Florida Department of Citrus*, 456 U.S. 1002, 102 S.Ct. 2288, 73 L.Ed.2d 1297 (1982); *State ex rel. Walters v. Blackburn*, 104 So.2d 19 (Fla.1958); *Conner v. Sullivan*, 160 So.2d 120, 122 (Fla. 1st DCA 1963), *cert. denied*, 165 So.2d 176 (Fla.1964). See generally W. LaFave and A. Scott, *Handbook on Criminal Law* § 20, at 136-137 (1972).

"Moreover, in addition to the requirement that a statute's purpose be for the general welfare, the guarantee of due process requires that the means selected shall have a reasonable and substantial relation to the object sought to be attained

and shall not be unreasonable, arbitrary, or capricious. *See Nebbia v. New York*, 291 U.S. 502, 525, 54 S.Ct. 505, 510, 78 L.Ed. 940 (1934); *Lasky v. State Farm Insurance Co.*, 296 So.2d 9, 15 (Fla.1974); *L. Maxcy, Inc. v. Mayo*, 103 Fla. 552, 139 So. 121, 129 (1931).

In the instant action, the “means selected” has no reasonable relation to the “object to be attained,” if that object is to “prevent fraud.” The PIP Act is the epitome of “unreasonable, arbitrary, or capricious” legislation.

The 2012 PIP Act requires no showing of intent or *mens rea* when it criminalizes an innocent healthcare providers practice. The *Saiez* Court cited *Delmonico v. State*, 155 So.2d 368 (Fla.1963), “Fundamental to much of appellants' argument is the contention that the particular section of the statute here involved ... is improper because it fails to require proof of the intent essential to any crime such as a showing that the equipment was possessed with an intent to put it to unlawful use. Instead the law penalizes the mere possession of equipment which in itself is wholly innocent and virtually indispensable to the enjoyment of the presently lawful and unrestricted right of appellants in common with the public at large to engage in spearfishing in waters on all sides of the area covered by the statute.”

See also *Robinson v. State*, 393 So.2d 1076 (Fla.1980). (a statute that prohibited the wearing of any mask or covering “whereby any portion of the face is so hidden, concealed, or covered as to conceal the identity of the wearer” was deemed unconstitutional); *State v. Walker*, 444 So.2d 1137 (Fla. 2d DCA), *affirmed and lower court opinion adopted*, 461 So.2d 108 (Fla.1984) (the defendant had been charged with violating section 893.13(2)(a)7, Florida Statutes (1981), which prohibited the possession of a lawfully dispensed controlled substance in any container other than that in which the substance was originally delivered was ruled unconstitutional: “Nevertheless, despite a state's wide discretion, and the cautious restraint of the

courts, there remain basic restrictions and limits on a state's legislative power to intrude upon individual rights, liberties, and conduct. To exceed those bounds without rational justification is to collide with the Due Process Clause”).

In the instant case, as in *Delmonico*, *Robinson*, and *Walker*, the State has chosen a means which is not reasonably related to achieving *any* legitimate legislative purpose. It was unreasonable to criminalize the mere possession of embossing machines when such a prohibition clearly interfered with the legitimate personal and property rights. It should equally be found unconstitutional to use the PIP Act to achieve whatever purpose it was purportedly designed to advance, since it seems improbable that it will have any remedial impact, other than putting honest business people and their employees out of work.

As Judge Grimes phrased it in *Walker*, “without evidence of criminal behavior, the prohibition of this conduct lacks any rational relation to the legislative purpose” and “criminalizes activity that is otherwise inherently innocent.” 444 So.2d at 1140. Such an exercise of the police power is unwarranted under the circumstances and violates the due process clauses of our federal and state constitution. The PIP Act is a perfect example of legislation that fails the rational relationship test, and thus violates equal protection of the law. This flaw supports the Plaintiffs request for injunctive relief.

The conduct at issue with *these Plaintiffs*, the lawful provision of valid healthcare services, “gives no offense to any *recognized* standards.” See *Prior v. White*, 180 So. 347, 352 (Fla. 1938). As a chosen and legitimate profession, the medical facilities owned and operated by Plaintiffs, and the livelihood earned by those individuals providing services therein, *must* be evaluated under the standards articulated in *Prior v. White*:

It has been the trend of the decisions of this court to give effect to the constitutional guaranties of personal liberty and private property when the common good *did not*

fully justify or require their abridgement or curtailment to some extent by legislative measures, or to protect those rights fully and completely when they were of that inalienable and sacred character which the language of the Constitution protects from any invasion whatever, *regardless of the temporary will of majorities* or the *supposed* requirements of the general welfare. Indeed, our decisions recognize the fact that the principles embodied in our Declaration of Rights have their roots deep in the past and are the rich fruitage of centuries of bitter struggle by our forefathers against the exercise of arbitrary, oppressive, and autocratic governmental power in all its forms.” *Id.* at 354. (Emphasis added.)

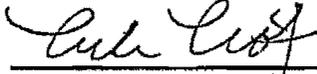
Because the PIP Act is neither reasonable nor necessary, and it allows, if not mandates unfair and discriminatory treatment of different healthcare professions, it must be found invalid and enjoined.

III. CONCLUSION & PRAYER FOR RELIEF

The denial of the Plaintiffs’ fundamental Constitutional rights represents a substantial threat of injury and irreparable harm to the Plaintiffs before a trial on the merits of this cause may be conducted. Plaintiffs meet and exceed the burden of demonstrating all 4 required elements for issuance of a Temporary Injunction. Plaintiffs respectfully seek preliminary injunctive relief because enforcement is scheduled to begin on January 1, 2013, because Plaintiffs will likely prevail on the merits of their claim, because Plaintiffs will each suffer irreparable harm, because Plaintiffs’ injuries far outweigh any damage to the state resulting from a temporary injunction, and because a temporary injunction is not adverse to the public interest. Because of the legal nature of the issues involved in this action and Plaintiffs’ prayer to vindicate fundamental protected Constitutional rights, no bond or security should be required of the Plaintiff upon the grant of a temporary injunction. Wherefore, Plaintiffs most respectfully request that this Honorable Court enter a Temporary Injunction enjoining Defendants from enforcing the provisions of the 2012 PIP Act until such time as this Honorable Court may conduct a trial on the merits of Plaintiffs’ cause.

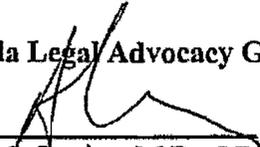
Respectfully submitted this 15th day of January 2013

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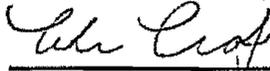
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Certificate of Service

I hereby certify that a true and correct copy of the foregoing was provided to Defendant via electronic mail to Defendant's Counsel, C. Timothy Gray at tim.gray@flor.com, and J. Bruce Culpepper at bruce.culpepper@flor.com and to the Florida Attorney General, Ms. Pam Bondi at pam.bondi@myfloridalegal.com.

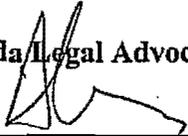
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AFFIDAVIT OF VERIFICATION

STATE OF FLORIDA)
COUNTY OF PINELLAS)

BEFORE ME, the undersigned authority, personally appeared ROBIN MYERS

who being duly cautioned and sworn deposes and says:

1. My legal name is ROBIN MYERS. I have direct personal knowledge of the facts stated herein and would be competent to testify to the same at trial.
2. I have read the foregoing Verified Complaint for Declaratory and Injunctive Relief along with the Plaintiffs' Motion for Injunction and the facts stated therein are true and correct.

FURTHER AFFIANT SAYETH NAUGHT.

[Signature]
Affiant:

DATE: 1.7.12

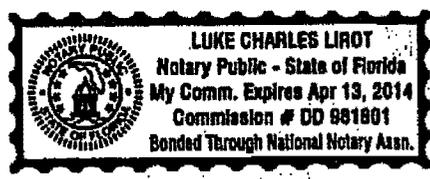
SWORN TO AND SUBSCRIBED BEFORE ME THIS 7th TH DAY OF JANUARY 2013 BY ROBIN MYERS, WHO IS PERSONALLY KNOWN TO ME OR WHO PRODUCED THE FOLLOWING IDENTIFICATION: N/A

[Signature]
Notary Public

DATE: 1.7.12

Notary Expiration Date: 4.13.14

Notary Seal:



AFFIDAVIT OF VERIFICATION

STATE OF FLORIDA)

COUNTY OF Hillsborough)

BEFORE ME, the undersigned authority, personally appeared Greg Zwin
who being duly cautioned and sworn deposes and says:

1. My legal name is Gregory Zwin. I have direct personal knowledge of the facts stated herein and would be competent to testify to the same at trial.
2. I have read the foregoing Verified Complaint for Declaratory and Injunctive Relief along with the Plaintiffs' Motion for Injunction and the facts stated therein are true and correct.

FURTHER AFFIANT SAYETH NAUGHT.

[Signature]
Affiant:

DATE: 1-8-13

SWORN TO AND SUBSCRIBED BEFORE ME THIS 8th TH DAY OF JANUARY 2013 BY Gregory S. Zwin WHO IS PERSONALLY KNOWN TO ME OR WHO PRODUCED THE FOLLOWING IDENTIFICATION:

Melba Reyes
Notary Public

DATE: 1-8-13

Notary Expiration Date: 7/22/14

Notary Seal:



AFFIDAVIT OF VERIFICATION

STATE OF FLORIDA)

COUNTY OF SARASOTA)

BEFORE ME, the undersigned authority, personally appeared Sherry L. Smith

who being duly cautioned and sworn deposes and says:

1. My legal name is Sherry L. Smith. I have direct personal knowledge of the facts stated herein and would be competent to testify to the same at trial.
2. I have read the foregoing Verified Complaint for Declaratory and Injunctive Relief along with the Plaintiffs' Motion for Injunction and the facts stated therein are true and correct.

FURTHER AFFIANT SAYETH NAUGHT.

Sherry L. Smith
Affiant:

DATE: 1/8/2013

SWORN TO AND SUBSCRIBED BEFORE ME THIS 8 TH DAY OF JANUARY 2013 BY Sherry L. Smith WHO IS PERSONALLY KNOWN TO ME OR ____ WHO PRODUCED THE FOLLOWING IDENTIFICATION: _____

Julie Ann Bifano
Notary Public

DATE: 1/8/2013

Notary Expiration Date: _____

Notary Seal:



JULIE ANN BIFANO
NOTARY PUBLIC - STATE OF FLORIDA
COMMISSION # EE129492
EXPIRES 12/28/2015
BONDED THRU 1-888-NOTARY1

AFFIDAVIT OF VERIFICATION

STATE OF FLORIDA)

COUNTY OF Hillsborough)

BEFORE ME, the undersigned authority, personally appeared CARRIE C DAMASKA

who being duly cautioned and sworn deposes and says:

1. My legal name is Carrie Christine Damaska. I have direct personal knowledge of the facts stated herein and would be competent to testify to the same at trial.
2. I have read the foregoing Verified Complaint for Declaratory and Injunctive Relief along with the Plaintiffs' Motion for Injunction and the facts stated therein are true and correct.

FURTHER AFFIANT SAYETH NAUGHT.

[Signature]
Affiant:

DATE: 1/10/13

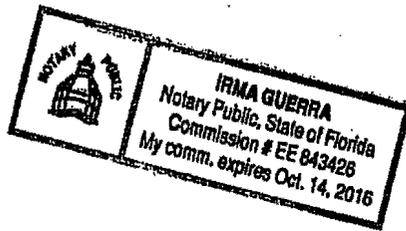
SWORN TO AND SUBSCRIBED BEFORE ME THIS 10 TH DAY OF JANUARY 2013 BY CARRIE C. DAMASKA WHO IS PERSONALLY KNOWN TO ME OR WHO PRODUCED THE FOLLOWING IDENTIFICATION: FLDL

[Signature]
Notary Public

DATE: 1-10-13

Notary Expiration Date: 10-14-16

Notary Seal:



ATTACHMENT 4

**IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR LEON COUNTY, STATE OF FLORIDA
CIVIL DIVISION**

ROBIN A. MYERS, A.P., an individual person
and Acupuncture Physician, GREGORY S.
ZWIRN, D.C., an individual person and
Chiropractic Physician, SHERRY L. SMITH, L.M.T.,
an individual person and Licensed Massage Therapist,
CARRIE C. DAMASKA, L.M.T., an individual
person and Licensed Massage Therapist, "John Doe,"
on behalf of all similarly situated health care providers,
and "Jane Doe," on behalf of all those individuals
injured by motor vehicle collisions,

Plaintiffs,

Case: 2013-CA-000073

v.

KEVIN N. McCARTY, in his Official Capacity as
Commissioner of the Florida Office of Insurance
Regulation,

Defendant.

**NOTICE OF HEARING FOR PLAINTIFFS' EMERGENCY MOTION TO VACATE
DEFENDANT'S NOTICE OF AUTOMATIC STAY**

Please take notice that on April 1, 2013 at 11:00 am, Plaintiff will call for hearing Plaintiffs' Emergency Motion to Vacate Defendants' Notice of Automatic Stay before the Honorable Terry P. Lewis located at 301 S. Monroe Street, Room 301-C, Tallahassee, Florida 32301.

Respectfully submitted this 27th day of March 2013

Luke Charles Lirot, P.A.,

/s/ Luke Charles Lirot, Esq.
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co-Counsel for the Plaintiffs

Florida Legal Advocacy Group of Tampa Bay, P.A.,

/s/ Adam S. Levine, M.D., J.D.
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co-Counsel for the Plaintiffs

Certificate of Service

I hereby certify that a true and correct copy of the foregoing was provided to Defendant via electronic mail to Defendant's Counsel, C. Timothy Gray at tim.gray@floir.com, and J. Bruce Culpepper at bruce.culpepper@floir.com and to the Florida Attorney General, Ms. Pam Bondi at pam.bondi@myfloridalegal.com.

Respectfully submitted this 27th day of March 2013

Luke Charles Lirot, P.A.,

/s/ Luke Charles Lirot, Esq.

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co-Counsel for the Plaintiffs

ATTACHMENT 5

1 IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
2 IN AND FOR LEON COUNTY, STATE OF FLORIDA
3 CIVIL DIVISION

4 CASE NO. 2013-CA-000073

5 ROBIN A. MYERS, A.P., an individual person
6 And Acupuncture Physician, GREGORY S.
7 ZWIRN, D.C., an individual person and
8 Chiropractic Physician, SHERRY L. SMITH,
9 L.M.T., an individual person and Licensed
10 Massage Therapist, CARRIE C. DAMASKA, L.M.T.,
11 An individual person and Licensed Massage
12 Therapist, "John Doe," on behalf of all
13 Similarly situated health care providers,
14 And "Jane Doe," on behalf of all those
15 Individuals injured by motor vehicle
16 Collisions,

17 Plaintiffs,

18 vs.

19 KEVIN N. McCARTY, in his Official Capacity as
20 Commissioner of the Florida Office of Insurance
21 Regulation,

22 Defendant.

23 PLAINTIFFS' EMERGENCY MOTION TO VACATE DEFENDANT'S
24 NOTICE OF AUTOMATIC STAY

25 DATE: Monday, April 1, 2013

26 TIME: 11:00 a.m. - 12:05 p.m.

27 PLACE: Leon County Courthouse
28 301 South Monroe Street
29 Tallahassee, Florida

30 REPORTED BY: NICOLE MAZZARA
31 Notary Public in and for
32 the state of Florida at
33 Large

34

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1 PROCEEDINGS

2 THE COURT: Well, little close but looks like
3 everybody got a seat anyway. Maybe they didn't,
4 maybe they did. Okay. So let's see. You filed a
5 motion on this side. I saw your motion, I saw the
6 response on the other side. So, anything you want
7 to add?

8 MR. LIROT: Judge, we were just going to hit
9 on the high points of our motion and see if you had
10 any questions and take it from there.

11 THE COURT: All right.

12 MR. LIROT: Very good. If it please the
13 Court.

14 Judge, Luke Lirot, I'm here for the
15 Plaintiffs. I'm here with Adam Levine, my
16 co-counsel. And, Judge, just by way of being clear
17 about the sequence of events here, if you remember
18 we had our oral argument on the motion for a
19 temporary injunction back on February 1st.
20 Sometime around the 10th, you asked for some
21 additional supplemental memoranda. We got those in
22 about Valentine's Day, noting the events here. And
23 then on March 15th, you issued your Order granting,
24 in part, the Motion for Temporary Injunction.
25 Thereafter the Office of Insurance Regulation

1 filed their Notice of Appeal on the 28th, and on
2 the same day we filed our Motion to Lift the Stay.
3 And what I would like to do this morning is just
4 talk to you a little bit about the cases that we
5 cited in our motion. And then I would like to turn
6 the floor over to Mr. Levine, who has some factual
7 presentation to make to support our request.

8 Judge, I think the cases are pretty clear. I
9 have a copy for you, and we put it up there on your
10 desk. The Court certainly does have the right,
11 obviously, the Appellate Rule 9.310(b)(2) allows
12 for the issuance of a stay when it's a governmental
13 entity that's actually filing the Notice of Appeal.
14 But that's not the end of the analysis. The
15 Circuit Court still maintains jurisdiction to
16 lift the stay if we can show that we have
17 compelling circumstances to support that. The
18 cases that I cited and actually, I think one of
19 them was yours, was the Reform Party of Florida v.
20 Black back in 2004. That was the Supreme Court
21 decision.

22 In that instance the Court talks about the
23 entitlement to seek a stay, and then also to try to
24 have that stay lifted. And, the Circuit Court
25 retains jurisdiction to entertain motions to lift

1 the stay, which is what we filed the same day that
2 the Notice of Appeal was filed. That case is at
3 885 So.2d 303, Supreme Court of Florida.

4 The other case is about the same issue as it
5 pertained to a civil forfeiture. And that case is
6 Gervais v. Melbourne, 890 So.2d 412. And that was
7 the -- that case was the Fifth District Court of
8 Appeal case. It again goes through the criteria
9 that the Courts look at when determining whether or
10 not to lift the stay. And I think the last
11 paragraph says that, "We note the Automatic Stay
12 Rule does not permit the Lower Tribunal at the
13 discretion to -- we note that the Automatic Stay
14 Rule does permit the Lower Tribunal the discretion
15 to vacate the stay," and then it cites the other
16 cases that we have.

17 The other one that we cited to support the
18 proposition that you have the authority to vacate
19 that stay is, Saint Lucie County v. North Palm
20 Development Corporation. That's found at 444 So.2d
21 1133, Fourth District Court of Appeals case. It's
22 interesting in that case because what they did is
23 they decided it would be important to stop the --
24 allow the stay to stand so that the developers that
25 were the parties that were benefiting from the

1 injunction wouldn't initiate building a development
2 in the instance if, in fact, the Appellate Court
3 would reverse the decision.

4 The last case that we have, Judge, is the
5 Tampa Sports Authority v. Gordon Johnson case. And
6 this, I think, is probably the most relevant to the
7 point that we hope to raise, because there Mr.
8 Johnson was challenging the policy adopted by the
9 Tampa Sports Authority to frisk all of the
10 attendees at Buccaneer football games, and he got
11 an injunction.

12 And what they looked at was the same criteria.
13 In fact, they articulate those tests saying that,
14 "It's really the same criteria we look to, to
15 determine whether or not we are going to lift the
16 stay, whether or not those establish a compelling
17 circumstance." And in that instance, they looked
18 at the balancing of the interest of the parties who
19 would suffer more. It really just came down to
20 that.

21 And, in our case, Judge, I think if you look
22 at the context of the injunction that you granted,
23 it really is not as expansive as opposing counsel
24 would try to have the Court believe. It really --
25 from our perspective, it eliminates, as you recall,

1 the emergency medical condition as a prerequisite
2 to the full policy limits of the PIP coverage, and
3 it also lifts the prohibition against licensed
4 massage therapists and acupuncturists from being
5 able to provide those services, and chiropractors
6 being able to provide services in excess of the
7 \$2,500 limitation imposed by the act.

8 In your Order, as we articulated in our
9 complaint, the people we represent are out of
10 business. They -- you know, certainly for the
11 licensed massage therapists and the acupuncturists,
12 they cannot do the job that they studied and
13 prepared to do in providing these health care
14 services to people that are injured in automobile
15 accidents. And, candidly, the chiropractors are in
16 the same position.

17 Dr. Frank is here, and I know he's going to
18 give you some testimony as to what the limitations
19 of the \$2,500 limit is on his practice. And quite
20 honestly, Judge, we reviewed all of the pleadings
21 that were filed, the irreparable harm that we
22 alleged that you found, and in the response papers,
23 Judge, the arguments really just come down to pure
24 time and economic damages. Nowhere in any of the
25 response to our emergency motion to lift the stay

1 does the Office of Insurance Regulation say
2 anything about their suffering any kind of
3 irreparable harm.

4 They talked about developing rates and forms,
5 and the number of filings that they had from the
6 different insurance companies, problems that they
7 would have because they've listed and issued a
8 number of new policies that reflect these new
9 limits. And they talk about the PIP Act being
10 halted.

11 Well, that's not what the injunction does.
12 It does not halt the PIP Act, it simply imposes
13 limitations on those specific criteria that you
14 identified in your Order. And again, it's talking
15 about the third-party insurance companies'
16 financial interests, not the interests of the
17 Florida consumer.

18 So, our position is that if you are to weigh
19 these competing interests, they're complaining
20 about disruption, we're complaining about
21 devastation and people that are in health care,
22 providing services that can't earn a living. So, I
23 think based on the balancing of the harm, and I
24 talked with Mr. Levine about this, he urged me to
25 bring this up, we look at this as forms over

1 substance. That the issuance of these different
2 forms and having the insurance companies have to
3 make these minimal changes, really does not
4 outweigh the irreparable harm that this Court found
5 that's occasioned on licensed massage therapists,
6 acupuncturists, and chiropractors desirous of
7 delivering the full extent of their services under
8 PIP coverage as it used to exist. So --

9 THE COURT: Not to mention the injured person.

10 MR. LIROT: Exactly.

11 THE COURT: Who can't get insurance coverage.

12 MR. LIROT: That's correct. And therein lies
13 the reason that we think the citizens of Florida,
14 the consumers, those being the injured persons,
15 they're suffering as well from the imposition of
16 these particular restrictions. So we're not
17 asking, and the Court did not find that the entire
18 PIP Act had to be set aside.

19 I don't know the extent of the effort that
20 would have to be taken by the insurance companies
21 to have to correct this, but having studied how
22 they adopted and implemented the changes that were
23 brought about by the adoption of the challenged
24 legislation, it seems to me relatively easy to send
25 out a memo, an e-mail to the people and say, "Look,

1 here are some very, very minor changes. There is
2 no longer the requirement that people seeking
3 coverage have to establish that emergency medical
4 condition, and there's no longer a prohibition
5 against licensed massage therapists and
6 acupuncturists who provide services that they have
7 historically done prior to the adoption of this
8 challenge legislation."

9 So, based on that, Judge, and the compelling
10 circumstances and the balancing of the harms, I
11 don't think other than disruption, an
12 inconvenience, and what really, if you refine it
13 down to its lowest common denominator, is simply an
14 economic loss to the insurance companies. It
15 seemed a little bit strange to us that the Office
16 of Insurance Regulation would be trying to defend
17 the insurance companies rather than trying to
18 protect the Florida consumer. But be that as it
19 may, nothing in the papers that they filed has
20 alleged any irreparable harm, and we feel that the
21 compelling circumstances that are exhibited by the
22 Plaintiffs in this action outweigh whatever results
23 will occur from the affectation of this injunction
24 against the Office of Insurance Regulation.

25 And with that, Judge, I would like to go ahead

1 and cede the floor to Mr. Levine if I could.

2 THE COURT: All right.

3 MR. LEVINE: Your Honor, thank you. Adam
4 Levine. Again, briefly, Your Honor, I provided you
5 on your desk a copy of all the affidavits that we
6 filed in the black binder. They're alphabetized.
7 I actually color-coded them to make it easy. This
8 morning there were just a couple of high points
9 that I wanted to hit on, and then I thought I would
10 leave them with you for your reading pleasure.

11 In looking at what we've been talking about,
12 the State of -- the Office of Insurance Regulation
13 filed an affidavit that basically said that the
14 auto insurance industry was going to sustain
15 economic losses and time and money to revert back
16 the pre-January 1st, forms and papers that were
17 done, and if any -- the Office of Insurance
18 Regulation had to review approximately 446 forms
19 and filings.

20 What we've provided Your Honor with is a
21 statement from massage therapist Reeve, who is the
22 lavender tab, who said that she was not able to
23 quantify her losses because her referrals stopped.
24 We're not talking about just economic -- mere
25 economic losses and loss of a business that is

1 potentially compensable, we're talking about the
2 fact that her referrals have stopped and the
3 relationship has stopped and that is irreparable
4 harm.

5 Massage therapist Pendum, who is the bright
6 pink tab, says she has lost goodwill. She has lost
7 her ability to have a patient-provider relationship
8 because the patients stopped coming in when the
9 \$2,500 limit is reached. The affidavit of Ms.
10 Lawrence, who I'm not sure if we'll hear from
11 today, says in the last paragraph, "Well, gee, I
12 haven't heard of any insurance companies saying
13 that they can find a doctor to say there's no
14 emergency medical condition."

15 We would say it's quite the opposite, and I'll
16 bring up a witness for three minutes who will
17 explain that that's not the case. In fact, if you
18 look at the affidavits under the dark blue tab, Dr.
19 Fulton, who is a chiropractor, provided you with a
20 copy of an explanation of benefits form where the
21 treatment was allowed for the first visit and then
22 was stopped immediately thereafter when it was
23 reached from one insurance provider. Dr. Fulton
24 said that without the care his patients are not
25 receiving the best care that they can.

1 Dr. Crespo, who is a medical doctor, said that
2 massage is the most beneficial treatment available
3 for people in an auto accident. And he said that
4 the 2012 PIP Act, "Severely limits medically
5 necessary and scientifically proven medical
6 treatment." There are also a number of concerns
7 from many of the massage therapists in the
8 affidavits.

9 That massage therapist Kydar is under the
10 green tab, and massage therapists Hernandez, Bravo
11 and Pardino, who I didn't tab each of them, who
12 also said that they are having a significant issue
13 because of the economic loss from having a decrease
14 in their business, they can't pay either their
15 business loans or their student loans. So they are
16 not able to do business and it's not able to keep
17 them in business.

18 One of the chiropractors, Dr. Hanson, said
19 that he's going to have to go bankrupt. That he's
20 invested his life savings in his practice and
21 because of the denials he's getting after that
22 \$2,500 limit, \$2,500 limit, he is no longer able to
23 do business because he can't continue to employ the
24 massage therapists and the assistants that work
25 with him.

1 address is 4455 North Ninth Avenue, Pensacola, Florida.

2 Q And just very briefly for the Court, what's
3 your background and your experience so that you can
4 testify on behalf of chiropractors, generally?

5 A I was -- graduated in 1988. I'm a
6 chiropractor in Pensacola, Florida specializing in the
7 treatment of musculoskeletal injuries. I have a large
8 facility that employs two physical therapists, three
9 PTAs and a massage therapist.

10 I am a member of Ascension Health Care. I am
11 a Primary Tier I physician with Sacred Heart Health
12 Systems. I was contracted with the hospital, which is a
13 large 600-bed hospital. We also have facilities in
14 Destin and also a new hospital in Port St. Joe.
15 My practice specializes in treatment of patients who
16 have been injured in motor vehicle accidents. Also, I
17 have a fair amount of patients that have major medical
18 problems, that's sports injuries, pediatrics. And I
19 also do a small percentage of independent compulsory
20 medical reviews and peer reviews. And a small portion
21 of that is doing defense work for insurance companies.

22 Q In your experience, are you familiar with the
23 2012 PIP Act?

24 A Yes, I am.

25 Q And how has the 2012 PIP Act affected your

1 practice?

2 A Well, the 2012, has severely restricted and
3 limited my patients to access proper medical care. It's
4 also limited my ability to deliver proper medical care.
5 I have patients that once the \$2,500 amount is reached,
6 patients either drop out of care because they are
7 fearful of incurring bills after the \$2,500.
8 So if I can't bring a patient to maximum medical
9 improvement or to threshold, we can't pursue a claim in
10 court for those patients.

11 Also, it restricts my ability to have patients
12 referred out for advanced diagnostic imaging, such as CT
13 scans, MRIs. The patient gets involved in a motor
14 vehicle accident, Your Honor, they take an \$800
15 ambulance right to the hospital. They're evaluated,
16 they're maybe doing a plain film set of x-rays, lumbar
17 films, possibly a CT scan of the head or neck, they're
18 given three prescriptions and they're released and
19 they're sent out on the street. God forbid that, you
20 know, they still have pain. Generally some of these
21 patients go to sleep, they can't wake up, they can't get
22 out of bed in the morning, and they need to seek further
23 care.

24 I had a little incident where, you know,
25 personally, my mother was involved in a motor vehicle

1 accident 10 months ago, and she was rear ended by an
2 uninsured motorist. She -- two young people, my dad is
3 87, my mom is 85, they live outside of Boca Raton,
4 Florida, and she injured her shoulder, and they both
5 have pacemakers.

6 And so, she went to the hospital and she had
7 to be checked by an electrophysiologist to see that the
8 leads were not taken out of her pacemaker. And she had
9 to have extensive rehabilitation to her left shoulder.
10 So I look at these injured people that after they go to
11 the hospital their \$2,500 is met, that if they get up in
12 the morning, and a mother can't take care of her
13 children, a father can't go to work, provide for his
14 family and a daughter or son can't go to school, those
15 are big issues.

16 So, these patients are relying on pain
17 medication and muscle relaxers to take care of their
18 problems. The -- this PIP law restricts my protocol, my
19 plan.

20 I have a loss of referrals. Sixty percent of
21 my referral business is from doctors. Doctors are
22 calling me all the time asking me about what's the
23 definition of emergency medical condition and I can't
24 give it to them because it's very vague and ambiguous.
25 So it's had a decrease in my practice referrals,

1 patients have dropped out of care.

2 It's also affected my clinical
3 decision-making. You know, some patients when they've
4 been involved in an accident, they -- their adrenaline
5 levels are high, their cortisol levels are high.
6 They go to the hospital, they come home and then all of
7 a sudden, maybe a week, three weeks, four weeks later
8 they bend over to pick up a toothbrush off of the sink
9 and maybe they've had some disruption in a disc, an
10 angular or circumferential tear in a disc and they
11 sneeze and a disc blows and they drop to their feet.
12 And so these people now after having been to a hospital,
13 they're out of luck.

14 They can receive anymore care, and I can't do
15 my job and I can't deliver proper health care to these
16 patients. So, it's about people. And my crux has
17 always been about taking care of people. And my motto
18 has been, if I take care of the people in my practice,
19 my practice has always taken care of me.

20 MR. LEVINE: Your Honor, may I approach?

21 THE COURT: Okay.

22 BY MR. LEVINE:

23 Q Okay. I've showed this to them. Dr. Frank,
24 I'm handing you what I've marked as Exhibit A. Can you
25 identify that?

1 A Yes, it's a --

2 Q Can you describe it?

3 A -- explanation of benefits for one of my
4 patients.

5 (Whereupon, Exhibit A was marked for
6 identification and received in evidence.)

7 BY MR. LEVINE:

8 Q Okay. You provided that form to me?

9 A Yes, I did.

10 Q And the reason I'm handing that to you, Dr.
11 Frank, is to show that emergency -- that patients are
12 not getting provided with the full \$10,000 in coverage.
13 The affidavit that I believe we provided you a copy from
14 Sandra Soren that says in the end that she didn't
15 believe that insurance carriers were denying coverage.

16 Has it been your experience that insurance
17 carriers since January 1st, are denying the \$10,000 in
18 coverage?

19 A They are starting to now because the policies
20 are now becoming renewed. And so, we're starting to see
21 this. I don't think it's hit a head until maybe June,
22 July, August, when all these policies are renewed.

23 Another thing is about massage therapy, it's
24 such an integral part of what I do. It's a very valid
25 science. It's the only way to really deal with

1 myofascial spasms and my physical therapists generally
2 refer to that all the time.

3 Q If you look at that explanation of benefits
4 form that you have, is that essentially the same verse
5 that you provided me with?

6 A Yes, it's exactly the same.

7 Q The only thing that's been redacted is the
8 individual's identity?

9 A That's correct.

10 MR. LEVINE: Your Honor, with any objections I
11 would like to introduce this as Exhibit A.

12 MR. CULPEPPER: I have no objections.

13 THE COURT: All right.

14 MR. LEVINE: I will provide you with a copy of
15 that. And I think with that, Your Honor, we would
16 like to stop at the moment and --

17 THE WITNESS: Can I add one more thing? This
18 issue really shifts the burden of accidents on to
19 the victims, and it limits patient access. And it
20 really restricts the insurance companies from
21 paying legitimate claims.

22 THE COURT: Cross-examine?

23 MR. CULPEPPER: Do you mind if I ask questions
24 from here?

25 THE COURT: That's fine.

1 CROSS EXAMINATION

2 BY MR. CULPEPPER:

3 Q I apologize, tell me your last name.

4 A Frank.

5 Q Frank. Dr. Frank, I'm Bruce Culpepper, I
6 represent the Office of Insurance Regulation. Just a
7 few follow-up questions.8 In these explanation of benefits, I didn't see
9 the point where they say, "We're going to cap at \$2,500
10 for reimbursement. In order for -- to make any
11 additional reimbursement decisions please provide the
12 determination of patient's emergency medical conditions.
13 So, USAA is telling the patients, "If you have an
14 emergency medical condition we'll pay more."15 Do you know -- are you aware if any of your
16 patients have gotten a statement from a doctor that they
17 do, in fact, have an emergency medical condition?18 A Well, first of all, I don't understand
19 emergency medical condition. It's very -- extremely
20 vague and --21 Q I'm asking about the -- tell me about your
22 patients.

23 A Okay. Could you repeat the question, please?

24 Q Explanation of benefits says, "USAA will pay
25 more if the patient will provide a determination of the

1 patient's emergency medical conditions by a provider
2 authorized."

3 Are you aware of any of your patients that
4 have gone to a doctor and gotten a determination of
5 emergency medical condition?

6 A No, I'm not.

7 Q Okay. Okay. So, you're not aware of any or
8 you're aware that the patients have not been able to do
9 that?

10 A I'm not aware of any.

11 Q Okay. You've talked to doctors. You say 60
12 percent of your referrals are from doctors?

13 A Yes, sir.

14 Q Okay. And these are medical providers that
15 would be articulated in the statute, would they not?

16 A I'm not understanding your question.

17 Q Okay. Medical providers, under the statute,
18 we talked about it, if there's a determination of an
19 emergency medical condition by a medical provider, and
20 you are familiar in this statute there's a list of
21 medical providers that can make that determination?

22 A Dentists and medical doctors, DOs, nurse
23 practitioners, everyone except a chiropractor. But we
24 can declare a non-emergency.

25 Q Okay. But your referrals come from those

1 entities, doctors, medical providers?

2 A Some of them, yes.

3 Q Right. And when -- so, are you saying that in
4 your conversations with these doctors, they're telling
5 you this patient does not have an emergency medical
6 condition, therefore, you are capped at \$2,500?

7 A Nobody has made the determination of an
8 emergency because nobody I believe understands it. I
9 have doctors calling me saying they don't understand it.

10 Q Okay. Now the statute says, "In order to be
11 capped there must be a determination that the person did
12 not an emergency medical condition."

13 So you are not receiving a determination from
14 a doctor that the patient you're treating has an
15 emergency medical condition, is that correct?

16 A I'm not understanding your question. I'm
17 sorry.

18 Q All right. You're talking to doctors, you get
19 referrals from doctors?

20 A I get referrals from patients, I mean, I don't
21 -- okay.

22 Q All right. And you say you also have patients
23 that come from the Emergency Room, right?

24 A I have patients that are referred to me
25 through other patients, I have patients that are medical

1 referrals, I have patients that are referrals from --
2 just from -- I do a TV show in town. I have patients
3 that come in off the street.

4 Q Do you treat other injuries, injuries other
5 than automobile accident injuries?

6 A Absolutely.

7 Q So you have sources of payment other than
8 personal injury protection, right?

9 A Yes, I do.

10 Q Okay. Do you have automobile insurance?

11 A Do I?

12 Q Yeah.

13 A Absolutely. I'm required to have it.

14 Q When was it renewed?

15 A I believe the renewal came around February.

16 Q Okay.

17 (Whereupon an off-the-record discussion was
18 held.)

19 BY MR. CULPEPPER:

20 Q Dr. Frank, are you aware of any of your
21 patients who stopped receiving payments under PIP at
22 2,500 that had been sued for their economic damages for
23 anything filed, claimed by you?

24 A My patients that have been sued?

25 Q Well, the injured party would have sued.

1 A No.

2 Q You're not aware of it?

3 A I'm not aware of it.

4 MR. CULPEPPER: Nothing further.

5 THE COURT: Okay. Any redirect?

6 MR. LEVINE: Your Honor, just one in response
7 to the last question that was asked.

8 REDIRECT EXAMINATION

9 BY MR. LEVINE:

10 Q Dr. Frank, you said earlier in the very
11 beginning, that you can't make the determination of a
12 permanent injury because your patients don't reach
13 maximum medical care?

14 A Because they dropped out of care and I haven't
15 finished my treatment protocol, or the physical
16 therapist hasn't finished.

17 Q Earlier, in the opening statement, the State
18 argued that patients don't have to drop out of care
19 because health insurance should provide a buffer. Has
20 that been your experience?

21 A Well, a lot of times health insurance will not
22 cover it and it's denied that the injuries are caused by
23 motor vehicle accidents. And some insurance policies
24 don't even cover, they lump physical medicine together.
25 And those are very limited, as well. Take Medicare, for

1 example.

2 I mean, they only cover spinal manipulation.
3 They don't cover any of the physiotherapy modalities,
4 such as electrical stimulation, interferential wave
5 current, ultrasound, myo-facial treatments,
6 neuromuscular treatments from a massage therapist. I
7 mean, those are vital portions of my practices to help
8 patients to get as well as I can get them and achieve
9 maximum therapeutic benefit from me.

10 Q Is it fair to say that the patients on the
11 explanation of benefit form that you have or this
12 patient specifically and your patients in general that
13 have been cut off at \$2,500 haven't reached any kind of
14 final visit or final care?

15 A Absolutely.

16 MR. LEVINE: No further questions, Your Honor.

17 The Court: All right. Thank you, sir.

18 Okay.

19 MR. LEVINE: Your Honor, with that I think we
20 should stop and move along on.

21 THE COURT: All right. Let's pick up on this
22 side.

23 MR. CULPEPPER: Your Honor, I would like to
24 call Sandra Starnes.

25 THE COURT: All right.

1 Whereupon,

2 SANDRA STARNES

3 was called as a witness, having been first duly sworn to
4 speak the truth, the whole truth and nothing but the
5 truth, was examined and testified as follows:

6 DIRECT EXAMINATION

7 BY MR. CULPEPPER:

8 Q Could you state your name, please?

9 A Sandra Starnes.

10 Q And where do you work?

11 A I work at the Office of Insurance Regulation.

12 Q What are your responsibilities there?

13 A I'm the Director of the Property and Casualty
14 Product Review Unit. My unit -- or I supervise the
15 people that review the rates and forms that insurance
16 companies use for property and casualty products.

17 Q And property and casualty, what's your
18 response -- your involvement with the auto insurance
19 industry?

20 A Well, when I first started at the Office I was
21 reviewing the auto rate guideline. After I was
22 promoted, you know, obviously, I took a strong interest
23 in House Bill 119. I provided several presentations for
24 House Bill 119, and have been kind of the point person
25 when it came to the implementation of House Bill 119.

1 Q So you're familiar with the -- the PIP Act is
2 what we're calling it, the Amendment?

3 A Very familiar.

4 Q Okay. And I'll direct you, because we're
5 focused on impact and the impact of any adjustments to
6 this law or invalidations in terms of it.

7 Can you tell the Court a little bit about
8 what's involved in making a rate filing? When an
9 insurance company has to make a rate filing and makes
10 rates and forms for PIP coverage limits, what's involved
11 in that?

12 A There's a lot of supporting detail that has to
13 go into it. Companies generally take a couple of months
14 at least to develop the rate filing, sometimes longer.
15 In general, if you were to request a PDF filing that the
16 office has reviewed, they can be hundreds, if not
17 thousands, of pages of information that the insurance
18 company submitted to support changes.

19 Q And then they submit those rate filings to
20 you?

21 A To the Office, and for rate filings actuaries
22 review the rate filings to determine whether or not they
23 comply with actual standards of the Florida Statutes.

24 Q How long do you and the Office have to review
25 rate filings?

1 A There are two options of filing under Florida
2 Statutes. There's a filing use in and a use in file
3 provision for auto. The file in use we're given 60 days
4 to review the filing. And if a final determination is
5 not made, then the insurance company can deem the file
6 approved.

7 However, if the Office needs additional time,
8 the company is willing to waive and go past that
9 60 days. On a use in file filing, the company submits
10 it within 30 days of starting to use the filing. So
11 there is no set time period that the Office has to
12 finish review of that filing, that type of file.

13 Q Okay. And just so I can summarize it, the
14 time that goes into calculating a rate filing, a company
15 you take -- you said several months is typical for a
16 company to calculate a rate filing for auto insurance?

17 A Yes.

18 Q Okay. And then the Office has 60 days after
19 that to review and approve the rate filing?

20 A Yes.

21 Q And add extensions if they're needed?

22 A Exactly.

23 Q Let's look at this PIP Act. When did the PIP
24 Act become law, are you aware?

25 A It was signed into law in May of 2012. There

1 were provisions that were actually effective July 1st,
2 and January 1st, of this year -- July 1st of last year,
3 January 1st of this year.

4 Q Okay. And I believe, if I can, Judge Lewis,
5 the PIP Act -- the coverage limits that we're talking
6 about, the \$2,500 cap and the exclusions for
7 acupuncturist and massage therapists, that case became
8 effective January 1, 2013?

9 A Correct.

10 Q The PIP Act was signed into law in May of last
11 year. When did insurance, auto insurers start to
12 calculate rates?

13 A They started about that time. They had an
14 October 1st, deadline to make a rate filing, pursuant to
15 the law. And every single insurance company that was
16 providing PIP had to make a rate filing. So they
17 started pretty soon after the law went into -- was
18 signed, in order to meet that October 1st deadline.

19 Q And then, so October 1st, and then so they --
20 what happened on October 1st? Excuse me. On October
21 1st, they had the deadline. Is that to file with the
22 Office?

23 A To file with the Office.

24 Q Okay. And then what did the Office do after
25 October 1st?

1 A The Office reviewed every single rate filing,
2 and determined whether or not they complied with the
3 requirements of the Florida Statutes and actuarial
4 standards.

5 Q Okay. Law goes into effect January 1, 2013.
6 Does that mean the auto insurance policies with the new
7 PIP limits went into effect on that date?

8 A The statute is actually unclear on that.
9 Because there is a provision in the statute that says
10 that an insurance company can implement the provisions
11 of House Bill 119 without it being specifically included
12 in the policy. So the insurance company didn't
13 necessarily need to issue a policy with the changes in
14 order to actually implement the provisions of the Bill
15 according to Statute.

16 Q Okay. Then let me ask you the practical
17 effect. Here we are on April 1st, January 1, all the
18 PIP coverage went into effect. What's happened with all
19 our insurance policies between January 1, and April 1?

20 A At this point in time, all the insurance
21 companies should be renewing their policies with new
22 policies with a benefit level. There might be some that
23 have held out with denial approval on their forms that
24 should be in the Office. But for the most part, they
25 should be at the new benefit level in their forms, as

1 well as the new rate level.

2 Q And I don't want to lose anybody, but I assume
3 every driver in the state of Florida would be covered by
4 insurance policies under the new PIP coverage limits?

5 A That's correct.

6 Q Okay. Let's talk about impact of the PIP
7 benefits, if -- you're aware that an injunction has been
8 granted to halt certain provisions of the PIP Act. If
9 that junction goes into effect today, and so, I assume
10 the impact would be that PIP coverage rates would be for
11 the old standard?

12 A Uh-huh.

13 Q All right. What is the effect on the auto
14 insurance industry?

15 A Well, there's several different things. First
16 of all, the auto in charge would want to revert back to
17 their old policy forms to get the level of benefits that
18 they're providing actually to meet within the forms of
19 the insurance that the insured has. But also, they
20 would want to revert back to their rate structure that
21 was in place before they accounted for the benefits of
22 the Bill.

23 Many insurers reduced their rates by 10
24 percent in order to meet the requirements of House Bill
25 119. Some didn't, some were able to support that they

1 needed a higher rate than that within the rate change.
2 But you can expect that once -- if this injunction were
3 to go into place, that most insurers would probably file
4 to reverse any decreases of the benefits from House Bill
5 119.

6 But not only that, the insurance company would
7 have to wait until they can implement those changes in
8 their system, which sometimes can take a significant
9 amount of time. And then they would have to set up
10 effective dates in order to implement it.

11 Because for renewal business you have to give
12 at least 45 days renewal notice of the premium before
13 you can actually charge it. So, at a bare minimum,
14 renewal business would be at the old rate structure at
15 least for the next 45 days if it were to go into effect
16 now. And that would be an inadequate rate for that
17 45 days, and the past three months that they've been
18 charging.

19 Q And I'm asking you about the comment that the
20 insurance industry could make the adjustment with just a
21 memo. Is just a memo enough to make these rate changes?

22 A No. There's no way that a memo would be able
23 to do that.

24 Q Okay. You talked about information you
25 received in your position about the impact of PIP

1 coverage benefits, and you made the comment that the
2 practical -- that you had not -- in your position, you
3 had not seen a significant practical impact. Can you
4 describe that for the Court?

5 A We've had several insurance companies call
6 because they have concerns about the emergency medical
7 condition and how they can limit to \$2,500 for the
8 non-emergency medical conditions. And several companies
9 have expressed even now that they found difficulty in
10 finding medical providers that would certify that it is
11 a non-emergency medical condition.

12 In which case the law states that if it's not
13 an emergency medical condition that you have to get a
14 certification in order to limit to \$2,500. So they're
15 kind of in a catch 22 because they have to get
16 certification that it is an emergency medical condition
17 to provide the \$10,000, or it is not a non-emergency
18 medical condition to limit to the \$2,500.

19 There's nothing in there that says, you know,
20 what do you do if you don't -- you're not able to get
21 certification. So I think a lot of companies have erred
22 on the side of caution because they don't want to be
23 charged with that fee if they cannot get a certification
24 for non-emergency medical condition that they pay the
25 \$10,000.

1 Q And one last area, again trying to get the big
2 picture here. We have the PIP Act which is in effect,
3 the PIP limits coverage. We have an injunction that's
4 been granted. If the injunction goes into effect, the
5 changes you have discussed have to be made. We haven't
6 gotten -- we don't have a final determination yet on the
7 case.

8 What happens if the injunction goes into
9 effect, the insurance industry acts and then the
10 Defendants prevail, so the Fifth Amendment stays law,
11 what is that affect on the insurance industry?

12 A Well, it would be a nightmare for both my
13 Office and for the insurance companies having to
14 reverse. We've had nine months to enact House Bill 119
15 so far. And we've taken that nine months, it's been,
16 you know, 450 filings that we've had to review. And
17 it's taken the full time in order to review those
18 filings.

19 In fact, we still have several filings that
20 are outstanding of those 450 filings. So, in order to
21 turn that around and, you know, in a short time period
22 and then have to re-implement it, it would just be a
23 nightmare.

24 MR. CULPEPPER: No further questions.

25 THE COURT: Cross-examine?

1 MR. LEVINE: If I may.

2 CROSS EXAMINATION

3 BY MR. LEVINE:

4 Q Good morning.

5 A Good morning.

6 Q A nightmare equates to a lot of time and
7 effort?

8 A Yes, and expense.

9 Q It can be done?

10 A It can be done.

11 Q So time and money?

12 A Uh-huh.

13 Q And you had mentioned that in the actual Act,
14 itself, that there was a provision that said that there
15 was really no need that the insurance companies change
16 their policies to implement the limitations that are the
17 subject of the injunction, yes?

18 A That's correct. But most companies have.

19 Q Well, they're changed their policies, but the
20 statute, itself, says you can implement these changes
21 without changing any of your paperwork.

22 A Right.

23 Q What's different about the injunction? Why
24 would they have to change their paperwork in order to
25 comply with an injunction?

1 A Well, first of the all, they would have to --
2 in order to charge an actuarial sound rate, they would
3 have to make a rate filing. That's approximately 155
4 filings right there. They wouldn't necessarily have to
5 provide policy form changes if they are going to provide
6 a higher benefit level than what is in their policy.
7 But most companies would just to have it out there so
8 that the insured knew exactly what they were purchasing.

9 Q So, the consumer ends up at the end losing
10 more money?

11 A Potentially, yes. I mean, the consumer will
12 lose out because they are going to lose the benefit of
13 the decreases in premiums that have come about because
14 of House Bill 119.

15 Q And those decreases in premiums are
16 commensurate with decreases in coverage and when you can
17 go to for treatment, yes?

18 A Yes.

19 Q Okay. Now you've talked about these rate
20 filings, and as I understand the PIP Act actually
21 required that by October 1st, that insurance companies
22 identify what kind of savings or decrease of premiums
23 would take effect.

24 A No. The House Bill required that there would
25 be a rate filing as of October 1st, and the insurance

1 company would show you -- it would file a 10 percent
2 decrease or provide a detailed explanation for why they
3 could not obtain that 10 percent.

4 Q How many detailed explanations did you get?

5 A We received about 150 filings, approximately.
6 Only about 35 of those used the minus 10 percent or more
7 of a decrease, so the rest of them would have had
8 detailed explanations.

9 Q Okay. So the goal of trying to reduce
10 premiums really only proved to be the case in what was
11 filed in your office in approximately one-third of the
12 insurance companies?

13 A Well, keep in mind that what the Bill was
14 really doing is it was changing the trajectory of the
15 PIP premiums. If you look at January 1st, 2011, and
16 forward, and you exclude House Bill 119, 85 percent of
17 the filings that the Office approved had increases in
18 PIP. And of those 85, the majority had double-digit
19 increases of PIP.

20 And we even had one insurance company that had
21 to increase their premiums by over a hundred percent in
22 order to maintain an actuarially sound rate.

23 Q Okay. And --

24 A So --

25 Q Finish, forgive me.

1 A So when you look at that trajectory, and you
2 look at over the time having double-digit increases, and
3 then all of a sudden you actually have a vast majority
4 of companies either having filing decreases or filing
5 their change in the premiums, then that's a positive
6 sign.

7 Q But those increases are based on what
8 information?

9 A They were based on an actuarial study that was
10 performed by Pinnacle Actuarial Resources, Inc.

11 Q All right. And is there any oversight or
12 independent research to verify the information that was
13 given to you by Pinnacle?

14 A Well, Pinnacle was the independent research.
15 We were -- we hired out with them, and then, you know,
16 they provided the report that was required by the
17 Legislature. Most companies use that report.

18 Q And where did they get their information?

19 A From a variety of places. They contacted
20 companies to get some information, they looked at
21 historical data, closed-claims studies, things like
22 that.

23 Q But the majority of that information would
24 come from the insurance companies themselves, yes?

25 A Or regulating organizations, yes.

1 Q Okay. That work for the insurance companies?

2 A Yes. I guess.

3 Q So there's never been any independent
4 peer-review research done into any of this information.
5 We've just kind of taken their word that all these
6 increases and problems exist?

7 A I'm not sure that I follow your question. I
8 don't know how you can get independent information
9 without getting information from the insurance company.

10 Q Obviously if you got that information, someone
11 else could review it. They could possibly come to a
12 different conclusion?

13 A You get 10 actuaries in a room, you could get
14 10 different numbers.

15 Q Okay. Now, again I just want to stress, the
16 issues that we're talking about as far as what would
17 have to be done to accommodate a stay being lifted and
18 consumers being allowed to just return to those minimal
19 components of actually not having to prove an emergency
20 medical condition to get their \$10,000 in coverage, and
21 having access to licensed massage therapists and
22 acupuncturists, that trade-off would be a suffering of
23 what? Just time and money on the part of the Office of
24 Insurance Regulation?

25 A Well, on our part it would be time and money

1 of the expense of having to review the filings. On the
2 insurance company's side they would have to have the
3 time and the expense and the hassle of, you know, having
4 to do the filings. Submit them, implement them, get
5 their ID systems up, you know.

6 In addition they would be having to go back
7 and review claims that they have had since January 1, to
8 make sure that it complies with the new law, so to
9 speak. And not only that, there might be some
10 additional bad faith involved. And there could be, you
11 know, additional expenses from that.

12 Q I just want to ask you one last question about
13 the certification of a non-emergency medical condition.

14 A Okay.

15 Q Where does that concept come from?

16 A I'm not sure I follow your question.

17 Q Well, as I understand it, the burden is on the
18 consumer to establish that they have an emergency
19 medical condition in order to enjoy the full \$10,000
20 benefits.

21 A There's a provision in the Bill that says that
22 if you want the \$10,000 in benefits that you have to get
23 certification from a medical provider that it's an
24 emergency medical condition. But there's also a
25 provision in the Bill that says that if it's going to be

1 limited to \$2,500 you have to have a medical provider
2 certify that it is a non-emergency medical condition.

3 Q And nobody will do that?

4 A I don't know that nobody will do that. What
5 I've said is that there have been several carriers that
6 have expressed to me the concerns that they have not
7 been able to find a medical provider, at that point, in
8 order to sign off on that.

9 Q And so those several carriers are
10 automatically allowing \$10,000 in coverage?

11 A There are some that are, yes.

12 Q So this injunction, if the stay is lifted and
13 the injunction is allowed to go into effect, it would
14 have no impact on those insurance companies that as a
15 matter of their own decision allow the full \$10,000 in
16 coverage?

17 A For those companies, correct. Unless they
18 find a way to limit to \$2,500 if they started getting in
19 the certifications.

20 Q All right. Would those companies have asked
21 for the rate reviews and things you are talking about?

22 A All the companies would have submitted the
23 filings. I don't know if the companies that I talked to
24 submitted the minus 10s or if they did the detailed
25 explanation.

1 Q Okay. But in your last example there are
2 companies that submitted for the changes in the forms
3 and all those administrative aspects that you talked
4 about, that are still providing \$10,000 of coverage to
5 their insured?

6 A Well, at this point in time, they're providing
7 the level of coverage that they feel they have to.
8 Until they get a provider that will certify that it's a
9 non-emergency medical condition.

10 Q And that's independent of whatever forms they
11 file allowing them to limit that to \$2,500?

12 A It's not independent of it. The forms say
13 that there has to be a certification that there's a
14 non-emergency medical condition. So they are following
15 the forms, and they are following the law.

16 MR. LEVINE: Okay. I have no further
17 questions. Thank you for your indulgence for just
18 one second. Nothing further.

19 THE COURT: Redirect?

20 MR. CULPEPPER: One question.

21 REDIRECT EXAMINATION

22 BY MR. CULPEPPER:

23 Q We talked about changes to the rate filings
24 and forms would take time and expense on insurance
25 companies. Who ultimately is going to bear the cost of

1 that expense for the insurance company?

2 A The expenses will be passed on in their rates
3 to the policyholder. So ultimately the policyholder
4 will end up paying for not only the expenses of having
5 to change that, but the higher cost if the benefits
6 increase.

7 Q Thank you.

8 MR. CULPEPPER: No further questions.

9 THE COURT: And I'm sorry, Ms. Starnes?

10 THE WITNESS: Starnes.

11 THE COURT: I thought they called you Stoner.

12 So, had there never been a PIP Act in 2000 -- I
13 guess was it passed in 2012? In 2012, when did the
14 insurance companies come to you to get approval of
15 the rate they want to charge?

16 THE WITNESS: The companies come to us
17 whenever they want to make changes in the rates.

18 THE COURT: How often can they come in to you?

19 THE WITNESS: They can come in every day if
20 they wanted to. In general, companies don't do
21 that. Most companies issue six-month policies, so
22 most of the time they will come in every six months
23 in order to adjust the rates.

24 THE COURT: What about in terms of -- the law
25 requires them to do an adjustment, right?

1 THE WITNESS: Uh-huh.

2 THE COURT: So if it had not been for the PIP
3 Act, there would be no different rate filings more
4 than the usual?

5 THE WITNESS: There were more than usual at
6 one point in time. So what I anticipate what will
7 probably happen even if the Bill stays and you
8 consider it to be okay, so for a while companies
9 will still do every six-months. So we'll probably
10 get bunches of filings every six months in
11 intervals. So we'll probably -- we should start
12 seeing an increase in filings right now for that
13 six months.

14 THE COURT: So if just in the usual average
15 workday, you expect every six months when policies
16 come up they may ask for a renewal or a rate
17 change, but they may not.

18 THE WITNESS: Right.

19 THE COURT: Do they -- and they present stuff
20 to justify that to you, don't they?

21 THE WITNESS: Yes, sir.

22 THE COURT: In this most recent thing, did
23 they present to you -- they just say, "Listen,
24 because of the new PIP Act we want to reduce the
25 rate," or they were required to, right?

1 THE WITNESS: Uh-huh.

2 THE COURT: Unless they came up with some
3 reasonable explanation as to why they couldn't do
4 it?

5 THE WITNESS: What we did -- there's no
6 explanation in the Bill about what a detailed
7 explanation was.

8 THE COURT: Right.

9 THE WITNESS: So if a company came in and they
10 were taking a minus 10 or more of a decrease, they
11 didn't have to provide any additional support.
12 They just said, "We're reducing our PIP rates by
13 minus 10 and that's it." What most companies did
14 though, is that they came in and they supplied what
15 we consider a detailed explanation. It complies
16 with all the requirements of Florida Statutes and
17 actuarial standards and principles that we would
18 normally expect in a rate filing. And our --

19 THE COURT: Well -- I'm sorry. Go ahead.

20 THE WITNESS: I was just going to say that our
21 rate filings can get very detailed, very quickly.

22 THE COURT: Aren't they mostly asking for more
23 when they come in to see you?

24 THE WITNESS: Actually, in general, yes. You
25 know, when you start from 2011 forward, PIP was

1 skyrocketing, double-digit rate increases were the
2 norm. If you look at House Bill 119 filings, and
3 just those --

4 THE COURT: Not those -- not the law we're
5 talking about.

6 THE WITNESS: Okay.

7 THE COURT: But just in general when they
8 come, aren't they usually asking, "Can we charge
9 more?" They can't be coming and asking to charge
10 less.

11 THE WITNESS: They do actually, believe it or
12 not. Yeah. Progressive has come in several times.

13 THE COURT: It's a competitive thing.

14 THE WITNESS: And done a lot of decreases.

15 THE COURT: Whatever it is, if they want to
16 raise it, they have to justify it to you, don't
17 they?

18 THE WITNESS: Yes, sir. Raising or lowering
19 they have to justify any changes.

20 THE COURT: Okay. All right. So that would
21 be the same if they want to change it now, won't
22 they?

23 THE WITNESS: Yes.

24 THE COURT: I mean, the law says they are
25 supposed to reduce it by 10.

1 THE WITNESS: Uh-huh.

2 THE COURT: Nothing's changed in that?

3 THE WITNESS: Nothing's changed in that.

4 THE COURT: Okay. Okay. Anything else based
5 on my questions?

6 MR. GRAY: Yeah -- oh. Based on your
7 questions? No, Your Honor.

8 THE COURT: Okay. All right. Thank you.
9 Anything else?

10 MR. GRAY: Yes. Do you mind if I just sit
11 here?

12 THE COURT: No, I don't. But actually it's
13 five of 12:00 and we've gone well over the
14 30 minutes we had. I'm going to pick a Jury this
15 afternoon. I've got a trial tomorrow. I would
16 say, "Let's come back when we can do it," but I
17 don't know when I'm going to have a chance to do
18 it. Is -- and I don't want to cut you off.
19 So I'm not sure what to do in this situation. I
20 guess I can just get with Laura and see. But I
21 don't have anymore time left.

22 MR. LEVINE: For time's sake, we're finished,
23 Judge. I think --

24 THE COURT: Well, I know that you are, but
25 they need to get their chance.

1 MR. LEVINE: I don't want to deprive them of
2 their right.

3 THE COURT: Well, do you have some more
4 evidence?

5 MR. GRAY: No, Your Honor, just arguments.

6 THE COURT: Just arguments?

7 MR. GRAY: Yeah. I'll make it as brief as
8 possible.

9 THE COURT: Okay.

10 MR. GRAY: The landscape is different today.
11 Had we been in here in the fall or the summer of
12 2012, it would be different. At last hearing
13 counsel said they couldn't get a hearing before
14 the date, and this is an exchange of e-mails
15 between Judge Carroll's office and Mr. Lirot that
16 shows at the lower portion of page 1 that they
17 could have gotten a hearing in December. But the
18 landscape changed dramatically.

19 And what Your Honor suggests is just couldn't
20 the rates have stayed in place had there been
21 something before January the 1st, that would be a
22 lot easier than trying to undo everything, redo it,
23 and then possibly redo it again if Your Honor is
24 overturned.

25 So, we think that there is -- that this

1 current status quo should be maintained because of
2 all the complications that has risen instead of
3 getting in here on December the 5th, and having the
4 hearing. All the complications that have been
5 created by waited until February, to get into a
6 court where they knew they had jurisdiction and
7 they knew they had a venue. I don't know why we
8 made the detour through Federal Court in Tampa.

9 Secondly, the affidavits, I don't know really
10 what to say about the affidavits and the testimony,
11 is that it's almost like -- almost like a res
12 loquitur is that there's a cottage industry that
13 has developed around PIP that is the cause for what
14 the Legislature was trying to hold down.

15 I want to emphasize that we're not here
16 opposing the consumer of Florida, we're here
17 supporting a decision made by the Legislature. And
18 that is what we're defending. We're not, as
19 suggested by counsel, we're not here to oppose the
20 consumer of Florida, because the consumer is also
21 being harmed by the fraud that is well documented
22 in the PIP system through higher rates and what
23 Governor Scott has called a hidden PIP tax from
24 that standpoint.

25 We would also like to note that if Your Honor

1 is going to lift the stay and vacate the stay, that
2 there is no bond that was required in Your Honor's
3 injunction ruling. The rule is clear that if you
4 have a -- that if you issue a temporary injunction
5 that you must have a bond. We think the bond
6 should not be a de minimus bond because of the cost
7 to the Office in terms of reviewing what would have
8 to be a whole new batch of filings. As well as --

9 THE COURT: Why would there have to be a whole
10 new batch of filings?

11 MR. GRAY: Because we're now entering into an
12 entirely new landscape. They just can't revert to
13 their old filings.

14 THE COURT: I thought the law required them to
15 reduce it by 10 or give you a reason why they
16 couldn't?

17 MR. GRAY: And so, now --

18 THE COURT: That's still in effect.

19 MR. GRAY: So now that that's all undone --

20 THE COURT: Why is it all undone?

21 MR. GRAY: Let me make this point since we're
22 in --

23 THE COURT: Well if I've got to make the
24 decision, you should want to answer my question.

25 Why would that undo it? If the law still requires

1 them to do that, how can they come out and say,
2 "Well, yeah, but this Judge over here ruled these
3 things not affable so we want to change our rate?"
4 I guess they could --

5 MR. GRAY: They could --

6 THE COURT: Ms. Starnes says they could come
7 in if they want to every day of the week and file
8 for a rate filing, but there's no reason why they
9 would have to.

10 MR. GRAY: Let me answer it this way, is that
11 I got a letter yesterday or over the weekend from
12 my pest control company that said, "You've been at
13 \$70 and we're only going to raise your rate by \$5,
14 but we're going to charge new customers \$90."

15 Well, that's a \$15 savings to me. But what
16 we're talking about is, we're talking about now
17 we're having all new customers come in and being
18 covered by the rate filings that would have to be
19 revised to reflect the increased cost that would
20 have been reflected had they not been mandated to
21 reduce their cost or explain otherwise.

22 The companies are entitled to a rate of return
23 and protection on their capital which is what Ms.
24 Starnes' office goes through. Simply -- we simply
25 contend that the current status quo is what should

1 be maintained, because if we're in an equitable
2 proceeding, which an injunction is, the record
3 clearly shows that this could have been decided
4 before January the 1st, and then wouldn't have
5 nearly the confusion and chaos that we are going to
6 have if the injunction is vacated.

7 One final request, Your Honor, is that if you
8 are going to vacate the injunction we would request
9 that you delay the vacation for 10 days to allow us
10 to file an emergency motion with the DCA to address
11 that ruling.

12 THE COURT: Yeah. I was going to ask you all
13 procedurally, I always thought the DCA could always
14 -- either way, could the DCA -- I know the DCA
15 could issue a stay. Could they vacate a stay?

16 MR. GRAY: They did that in the Pringle case.

17 THE COURT: The Pringle --

18 MR. GRAY: The Pringle case.

19 THE COURT: They vacated a stay?

20 MR. GRAY: Yes, the Judge issued a stay
21 regarding the net banned -- or had vacated the
22 stay, and the First DCA reinstated the stay.

23 THE COURT: Right. Has there been occasion to
24 do the opposite? In other words, if I don't grant
25 the motion, is there any appellate release? And

1 then I think it ought to be stayed while these --

2 MR. GRAY: My opinion is that there is
3 jurisdiction to do that, because it says that
4 whatever the Lower Tribunal does, that the Court
5 can then review that.

6 THE COURT: Do you all agree?

7 MR. LIROT: We agree, Judge. In fact one of
8 the cases actually says that, that it can be the
9 Trial Court or it can be the Court of Appeal.

10 THE COURT: Okay. Well, let me give you an
11 answer as quick as I can then. I've got your
12 filings and your arguments and I'll get you
13 something as soon as I can.

14 MR. LIROT: Thank you very much, Your Honor.

15 THE COURT: All right.

16 (Whereupon, the proceedings were concluded at
17 11:05 p.m.)

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1 CERTIFICATE OF REPORTER
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3
4

5 I, NICOLE MAZZARA, do hereby certify that I
6 was authorized to and did report the foregoing
7 proceedings, and that the transcript, pages 5
8 through 57, is a true and correct record of my
9 stenographic notes.

10
11 Dated this 8th day of April, 2013 at
12 Tallahassee, Leon County, Florida.

13
14 _____
15 NICOLE MAZZARA

16 Court Reporter
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