HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/CS/HB 895 Insurance
SPONSOR(S): Commerce Committee; Appropriations Committee; and Insurance & Banking Subcommittee; Santiago
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/HB 359, CS/CS/SB 1606

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Commerce Committee	15 Y, 9 N, As CS	Lloyd	Hamon

SUMMARY ANALYSIS

The bill makes the following changes regarding insurance:

Civil Remedies against Insurers

Florida law imposes a duty of good faith on an insurer in negotiating the settlement of a claim with the insured or a third party. This means the insurer must attempt in good faith to settle a claim when, under the circumstances, it can settle if it acts fairly and honestly toward its insured and with due regard to his or her interest. An insurer acting in bad faith may harm the insured party, by failing to settle a third party's claim against the insured, exposing the insured to greater liability. It could also harm a third party to the insurance contract by failing to settle its claim against the insured. Either an insured or a third party to the insurance contract can sue the insurer for bad faith. A jury decides whether the insurer acted in bad faith and determines the amount of damages.

- Claimant's Good Faith Requirement – The bill creates a statutory good faith obligation on the insured, claimant, and the representative of the insured or claimant and provides the insurer a defense against bad faith claims for failure to make good faith efforts to cooperate with the insurer's claim investigation.
- Bar to Civil Remedy – The bill prohibits a third-party lawsuit for insurer bad faith in a liability claim, if there is a single claimant and the insurer paid the lesser of the claimant's demand or policy limits or if there are multiple claimants and the insurer submits the matter at policy limits to the court for resolution of the claimant's percentage share of the policy limit amount either within 90 days following the second notice of claim or during the 60-day cure period following receipt of the required pre-suit notice; upon resolution of the action, the claimants must release the insured(s) from liability.
- Filing of Pre-Suit Notice and Tolling of Statute of Limitation – Florida law requires a pre-suit notice to the Department of Financial Services (DFS) and the insurer 60 days prior to suing on a bad faith claim, but no particular insurer address is specified. The bill requires the insurer to designate an email address for delivery of the notice and mandates that DFS forward notices to that email address. It starts the 60 days from the day the DFS receives a delivery receipt for the forwarded notice. In addition, it extends the statute of limitation from 65 days to 60 days, since a grace period for physical mail processing is no longer needed.

Motor Vehicle Personal Injury Protection

Florida's Motor Vehicle No-Fault Law requires motorists to carry no-fault insurance known as personal injury protection (PIP) coverage. In exchange for a limited exemption from tort liability, drivers receive $10,000 in emergency medical and disability benefits ($2,500 for non-emergency medical conditions) and certain other benefits. Medical benefit payments are overdue if not paid within 30 days. Medical providers may sue insurers for overdue payments only after filing a written pre-suit notice known as a PIP demand letter. The law specifies the minimum content of the demand letter.

- PIP Medical Reimbursement – The bill changes maximum allowable charges for emergency care by a hospital or in a hospital by a physician or dentist from 75 percent of usual and customary charges to 200 percent of Medicare.
- Pre-Suit Notice (Demand Letter) –The bill increases requirements governing the content of the demand letter, including line item detailing of the amounts in dispute and proof of emergency medical condition, if applicable. It requires the demand letter to comply with statutory requirements. The bill bars a subsequent lawsuit if the demand letter was not compliant, the insurer fully paid the claim, or the charge was not included on a demand letter. It allows the insurer an award of attorney fees for defense of a barred claim.

The bill has no impact on state or local government revenues or expenditures. It may have positive and negative impacts on the private sector.

The bill is effective on July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Obligations of Insurer to Insured

A liability insurer generally owes two major contractual duties to its insured in exchange for premium payments—the duty to indemnify and the duty to defend. The duty to indemnify refers to the insurer's obligation to issue payment to either the insured or a beneficiary on a valid claim. The duty to defend refers to the insurer's duty to provide a defense for the insured in court against a third party with respect to a claim within the scope of the insurance contract.[1] The Florida Supreme Court explained the difference between indemnity policies and liability policies:

> Under indemnity policies, the insured defended the claim and the insurance company simply paid a claim against the insured after the claim was concluded. Under liability policies, however, insurance companies took on the obligation of defending the insured, which, in turn, made insureds dependent on the acts of the insurers; insurers had the power to settle and foreclose an insured's exposure or to refuse to settle and leave the insured exposed to liability in excess of policy limits.[2]

Historically, damages in actions for breaches of insurance contracts were limited to those contemplated by the parties when they entered into the contract.[3] As liability policies began to replace indemnity policies as the standard insurance policy form, courts recognized that insurers owed a duty to act in good faith towards their insureds.[4]

Common Law and Statutory Bad Faith

Florida courts for many years have recognized an additional duty that does not arise directly from the insurance contract, the common law duty of good faith on the part of an insurer to the insured in negotiating settlements with third-party claimants.[5] The common law rule is that a third-party beneficiary who is not a formal party to a contract may sue for damages sustained as the result of the acts of one of the parties to the contract.[6] This is known as a third-party claim of bad faith.

At common law, the insured cannot raise a bad faith claim against the insurer outside of the third-party claim context.[7] In 1982, the Legislature enacted s. 624.155, F.S. Section 624.155, F.S., recognizes a claim for bad faith against an insurer not only in the instance of settlement negotiations with a third party but also for an insured seeking payment from his or her own insurance company. This is known as a first-party claim of bad faith.

Section 624.155, F.S., provides that any party may bring a bad faith civil action against an insurer, and defines bad faith on the part of the insurer as:

- Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured with due regard for her or his interests;
- Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

[1] *See* 16 Williston on Contracts s. 49:103 (4th Ed.).
[2] *State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[3] *Id.*
[4] *Id*.
[5] *Auto. Mut. Indem. Co. v. Shaw*, 184 So. 852 (Fla. 1938).
[6] *Thompson v. Commercial Union Insurance Company*, 250 So.2d 259 (Fla. 1971).
[7] *Laforet*, 658 So.2d at 58-59.

- Except as to liability coverages, failing to promptly settle claims, when the obligation to settle the claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.[8]

In order to bring a bad faith claim under the statute, a plaintiff must first give the insurer 60 days written notice of the alleged violation. The insurer has 60 days after the required notice is filed to pay the damages or correct the circumstances giving rise to the violation.[9] Because first-party claims are only statutory, a first-party insurer bad faith cause of action does not exist until the 60-day cure period provided in the statute expires without payment by the insurer.[10] Third-party claims, on the other hand, exist both in statute and at common law, so the insurer cannot guarantee avoidance of a bad faith claim by curing within the statutory period.[11]

In interpreting what it means for an insurer to act fairly toward its insured, Florida courts have held that when the insured's liability is clear and an excess judgment is likely due to the extent of the resulting damage, the insurer has an affirmative duty to initiate settlement negotiations.[12] If a settlement is not reached, the insurer has the burden of showing that there was no realistic possibility of settlement within policy limits.[13] Failure to settle on its own, however, does not mean that an insurer acts in bad faith. Negligent failure to settle does not rise to the level of bad faith. Negligence may be considered by the jury because it is relevant to the question of bad faith but a cause of action based solely on negligence is not allowed.[14]

Third-Party Claims of Bad Faith

A third-party bad faith claim arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage.[15] The Florida Supreme Court has described an insurer's duty to its insureds:

> An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured. This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Because the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, negligence is relevant to the question of good faith. The question of failure to act in good faith with due regard for the interests of the insured is for the jury.[16]

In light of this heightened duty on the part of the insurer, Florida courts focus on the actions of the insurer, not the claimant.[17] Whether an insurer acted in bad faith is determined by the totality of the circumstances:

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[8] S. 624.155(1)(b)1.-3., F.S.
[9] *S.* 624.155(3)(d), F.S.
[10] *Talat Emterprises vv. Aetna Casualty and Surety Company*, 753 So.2d 1278, 1284 (Fla. 2000).
[11] *Macola v. Government Employees Insurance Company,* 953 So.2d 451 (Fla. 2006).
[12] *Powell v. Prudential Property and Casualty Insurance Company*, 584 So.2d 12, 14 (Fla. 3d DCA 1991).
[13] *Id*.
[14] *DeLaune v. Liberty Mutual Insurance Company*, 314 So.2d 601,603 (Fla. 4th DCA 1975).
[15] *Opperman v. Nationwide Mutual Fire Insurance Company*, 515 So.2d 263, 265 (Fla. 5th DCA 1987).
[16] *Boston Old Colony Insurance Company v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980)(internal citations omitted).
[17] *Berges v. Infinity Insurance Company*, 896 So.2d 665, 677 (Fla. 2005)(explaining that "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured").

> In Florida, the question of whether an insurer has acted in bad faith in handling claims against the insured is determined under the totality of the circumstances standard. Each case is determined on its own facts and ordinarily the question of failure to act in good faith with due regard for the interests of the insured is for the jury.[18]

The focus in a bad faith case is on the conduct of the insurer but the conduct of the claimant is relevant to whether there was a realistic opportunity for settlement.[19] A court, for example, will look at the terms of a demand for settlement to determine if the insurer was given a reasonable amount of time to investigate the claim and make a decision whether settlement would be appropriate under the circumstances. One court held that dismissal of a bad faith claim was proper where the settlement demand in question gave a 10-day window, pointing out that "[i]n view of the short space of time between the accident and institution of suit, the provision of the offer to settle limiting acceptance to 10 days made it virtually impossible to make an intelligent acceptance."[20] Although in this particular circumstance the court found that 10 days was not enough, it is not clear exactly what time period or other conditions for acceptance would be permissible, because courts look at the facts on a case-by-case basis and the current statute is silent on this point.

In *Berges v. Infinity Insurance Company*, dissenting justices expressed concern that there "is a strategy which consists of setting artificial deadlines for claims payments and the withdrawal of settlement offers when the artificial deadline is not met."[21] It was argued that it is a "common practice for a party contemplating litigation to submit a settlement offer that remains outstanding for only a finite period and that a person injured by a policyholder may set any deadlines he desires—even an arbitrary or unreasonable one."[22] Justice Wells concluded that set time periods in which all insurers must make decisions on claims and issue payments are needed.[23]

The majority in *Berges* held that courts must look to the totality of the circumstances. "The question of bad faith in this case extends to [the insurer's] entire conduct in the handling of the claim, including the acts or omissions [of the insurer] in failing to ensure payment of the policy limits within the time demands."[24] Another court argued that setting a "minimum amount of time before any finding of bad faith is possible runs counter to the analysis of ordinary care and prudent business practice… Juries are empaneled to apply the appropriate criteria to the particular facts of a given situation and to decide whether the insurer acted prudently."[25]

In *Harvey v. Geico General Insurance Company*,[26] the Florida Supreme Court explained that the critical inquiry in a bad faith case is whether "the insurer diligently, and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment."[27] The court said an insurer has an affirmative duty to initiate settlement negotiations in cases where liability is clear and a judgment in excess of policy limits is likely.[28] The court said the lower court misapplied precedent when it said an insurer could not be liable for bad faith when the insured's own actions were at least in part responsible for the excess judgment.[29]

The Good Faith Duty in a Multiple Claimant Situation

In 2003, the Fourth District Court of Appeal considered how an insurer should carry out its duty of good faith in a case with multiple claimants where the total damages far exceeded policy limits.[30] In that

[18] *Berges*, 896 So.2d at 680 (internal quotations and citations omitted).
[19] *Barry v. GEICO General Insurance Company*, 938 So.2d 613, 618 (Fla. 4th DCA 2006).
[20] *DeLaune v. Liberty Mut. Ins. Co.*, 314 So.2d 601, 603 (Fla. 4th DCA 1975).
[21] *Berges*, 896 So.2d at 685 (Wells, J., dissenting).
[22] *Id.* at 692 (Cantero, J., dissenting).
[23] *Id*. at 686 (Wells, J., dissenting).
[24] *Berges*, 896 So.2d at 627.
[25] *Snowden ex. rel. Estate of Snowden v. Lumbermans Mutual Casualty Company*, 358 F.Supp.2d 1125, 1129 (N.D. Fla. 2003).
[26] *Harvey v. Geico General Insurance Company,* 259 So.3d 1 (Fla. 2018).
[27] *Id.* at 7.
[28] *Id.*
[29] *Id.* at 11.
[30] *Farinas v. Florida Farm Bureau General Ins. Co.*, 850 So.2d 555 (Fla. 4th DCA 2003).

case, the insured caused an automobile accident where five teens were killed and seven more were seriously injured. The insurance company settled with three of the claimants and exhausted policy limits on those settlements. Numerous claimants filed third-party bad faith claims against the insurer alleging the insurer entered into settlements without due regard for the interests of the insured.[31]

The court held that the same duties of good faith set forth in *Boston Old Colony* applied when there were multiple claimants. The insurer must investigate all claims, keep the insured informed, and minimize the amount of excess judgments by reasoned claim settlement. The insurer may still decide to settle some claims and exclude others but the decision must be made "in keeping with its good faith duty."[32]

In *Hernandez v. Travelers Insurance Co.*,[33] the court considered whether an insurance company, which may be liable to several persons because of the negligence of its insured, could file an interpleader action (an action where the court determines the distribution of the funds up to policy limits). The court held that interpleader is not allowed under such circumstances. The court explained:

> The plaintiff insurance company has only the derivative liability from its insured. One of its liabilities is to defend its insured in the courts. It may not discharge that liability by depositing a sum of money and saying to the courts, "divide it up." If the defendants were all claiming the proceeds of a single fund and liability could exist as to only one of the claimants, an interpleader would be appropriate. In the present cause, one action cannot determine the entire controversy and liability may exist as to more than one claimant.[34]

Pre-Suit Notice and Tolling of the Statute of Limitation

In order to bring a bad faith claim under the statute, a plaintiff must first give the insurer and the Department of Financial Services (DFS) 60 days' written notice of the alleged violation.[35] The 60-day period begins on the date the notice is filed. While the notice is required to be provided to both DFS and the insurer,[36] the statute is silent on what constitutes filing and whether the filing date is the date the notice is received by DFS or the date it was received by the insurer.[37]

The notice must include:

- The statutory provision which the insurer allegedly violated;
- The facts and circumstances giving rise to the violation;
- The name of any individual involved in the violation;
- Reference to specific policy language that is relevant to the violation, unless the person bringing the civil action is a third party claimant; and
- A statement that the notice is given to perfect the right to pursue a civil remedy.[38]

The statute of limitation for the filing of a lawsuit under s. 624.155, F.S., is tolled for 65 days following the issuance of the notice described above. This extends the claimant's right to sue the insurer until

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[31] *Id.* at 557-558.
[32] *Id.* at 561.
[33] 356 So.2d 1342 (Fla. 3rd DCA 1978).
[34] *See Hernandez*, 356 So.2d at 1344.
[35] S. 624.155(3)(a), F.S.
[36] Filing of the notice with the correct insurer has been held to be a condition precedent to maintaining a bad faith suit against the insurer. *Lopez v. GEICO Casualty Co.*, 968 F.Supp. 2d 1202, at 1209 (S.D. Fla. 2013). In *Lopez*, the plaintiff filed the notice with Government Employees Insurance Company, a similarly named sister company instead of the actual insurer, GEICO Casualty Company. Because the statute of limitation had run out following the flawed delivery of the notice, the *Lopez* case was dismissed with prejudice.
[37] Filing of the notice with DFS has been held to establish the date that starts the 60-day cure period. *Harper v. GEICO Gen. Ins. Co.*, 272 So. 3d 448 (Fla. 2nd DCA 2019). In *Harper*, the plaintiff filed the notice with DFS electronically on Dec. 19, 2013, and mailed the notice to GEICO with it being received by GEICO on Dec. 26, 2013. When GEICO later paid the claim on Feb. 21, 2014, the payment was 65 days from the date DFS received the notice, but 57 days from the date GEICO received the notice. The trial court held that GEICO paid the claim within the 60-day cure period. On appeal, the Second DCA held that the 60-day cure period ran from the date DFS received the notice. The result allowed the plaintiff to pursue a bad faith claim against GEICO for untimely payment of the claim.
[38] S. 624.155(3)(b), F.S.

after the conclusion of the 60-day period following the notice within which the insurer may respond to the notice by addressing the alleged violation.

Effect of the bill

Claimant's Good Faith Requirement

The bill creates a statutory good faith obligation on the insured, claimant, and the representative of the insured or claimant. They must act in good faith in providing claim information, their demands against the insurer, including setting deadlines that the insurer is expected to abide by, and in negotiating settlement opportunities.

The bill provides the insurer a defense against a claim of bad faith, if the claimant, the claimant's representative, or the insured failed to make good faith efforts to cooperate with the insurer's investigation of the claim. If the claimant, the claimant's representative, or the insured fails to make good faith efforts to cooperate in the insurer's claim investigation, then none of them may be able to pursue a bad faith claim against the insurer.

Bar to Civil Remedy against Insurers

In a third-party action for insurer bad faith regarding a liability claim, the action is barred, if:

- There is a single claimant and the insurer pays the claimant's demand or offers the policy limits, whichever is less, during the pendency of the claim through the end of the 60-day cure period following receipt of the required pre-suit notice.
- There are two or more claimants related to a single event whose combined claims exceed policy limits and the insurer submits the matter to the court to allow the court to determine the each claimant's relative share of the policy limits. Submission of the matter to the court must occur within 90 days of the second claimant filing a notice of claim or during the 60-day cure period that follows insurer receipt of the required pre-suit notice. Nonetheless, the insurer remains obligated to defend the insured. Upon disbursement of the interpleaded funds, the claimants are required to sign releases resolving the liability of the insured(s).

Filing of the Pre-Suit Notice and Tolling of the Statute of Limitation

The bill provides that DFS must forward the required pre-suit notice via email to the insurer. It also requires the insurer to designate an email address for the purposes of receiving such notices forwarded by DFS. Additionally, the bill clarifies that the:

- 60-day cure period runs from the date the insurer receives the notice from DFS at the designated email address, rather than following "filing," which is not currently defined.
- 60-day tolling begins when the department receives an email notice of receipt from the insurer.[39]

Since the notices will no longer be mailed and emailing them is a nearly instantaneous process, the bill changes the statute of limitation tolling period from 65 days to 60 days, thus removing the 5 days allotted for physical mailing through the postal service.

The bill requires the civil remedy notice to also include proof of the insured's legal liability and damages with supporting documentation.

Motor Vehicle Personal Injury Protection

Florida's Motor Vehicle No-Fault Law (No-Fault Law)[40] requires motorists to carry no-fault insurance known as personal injury protection (PIP) coverage. The purpose of PIP coverage under the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to who

[39] See Section III.C., Drafting Issues or Other Comments.
[40] Ss. 627.730-627.7405, F.S.

is responsible for a motor vehicle accident. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida motorists are required to carry $10,000 of PIP coverage.[41] However, motorcycles are excluded from this requirement.

PIP General Provisions

Required Coverage	All owners or registrants of motor vehicles with four or more wheels, except school buses, limos, and taxicabs, are required to carry PIP.[42]
Individuals Covered	The named insured, relatives living in the same household, persons operating the vehicle, passengers in the vehicle, and persons struck and injured while not occupying the vehicle.
Tort Limitation	Limited exemption from tort liability; injured persons may pursue certain tort claims as specified by the PIP law.
Benefits	$10,000 in emergency medical and disability benefits (limited to $2,500 in medical benefits for non-emergency medical conditions) and $5,000 in death benefits. Coverage of 60 percent of lost income due to disability, not to exceed the $10,000 overall benefit limitation.
Timely Treatment	Medical benefits are paid only if initial treatment is received within 14 days of the accident.
Timely Payment	Payments are overdue if not paid within 30 days of insurer receipt of written notice.
Medical Reimbursement	80 percent of reasonable medical expenses paid to eligible medical providers.[43]
Excluded Treatment	Massage and acupuncture are not PIP medical benefits. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.
Attorney Fees	Prevailing insureds and beneficiaries may receive a reasonable attorney fees award.

PIP Medical Reimbursement

For emergency care and services by a hospital and physicians and dentists providing such services in a hospital, the provider is allowed a maximum charge of 75 percent of usual and customary charges. They receive reimbursement for 80 percent of the allowed maximum charge.[44] This reimbursement yields a net 60 percent of usual and customary charges.[45] Emergency transport and treatment and non-emergency medical care and services are reimbursed at 200 percent of the allowable Medicare amount. This yields a net reimbursement of 160 percent of Medicare.[46]

Effect of the bill

The bill changes the maximum allowable charge for emergency care and services by a hospital and physicians and dentists providing such services in a hospital from 75 percent of usual and customary charges to 200 percent of the allowable Medicare amount. When reimbursement is made at 80 percent

[41] S. 627.7275, F.S. Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for Bodily Injury and Property Damage liability at the time of motor vehicle accidents or when serious traffic violations occur. The Financial Responsibility Law requires $10,000, per person, and $20,000, per incident, of Bodily Injury coverage, and $10,000 of Property Damage liability coverage.
[42] This includes non-resident owners who keep a vehicle in Florida for more than 90 days during the previous 365 day. S. 627.733(2), F.S.
[43] Insurers may limit reimbursements to a fee schedule tied to the Medicare allowed amount. S. 627.736(5)(a)1., F.S. For many services, 80 percent of 200 percent of the Medicare allowed amount is the standard reimbursement under this fee schedule.
[44] S. 627.736(5), F.S.
[45] 80% reimbursement of 75% of usual and customary charge equals 60% of usual and customary charge. 0.80 x 0.75 = 0.60
[46] 80% x 200% of Medicare = 60% of Medicare. 0.80 x 200 = 160

of the maximum allowed charge, emergency care and services provided by and in a hospital will be reimbursed at 160 percent of Medicare.

Pre-Suit Notice (Demand Letter)

Before anyone can sue for benefits under PIP coverage, they must file a written pre-suit notice with insurer. The pre-suit notice cannot be filed until the claim payment is overdue. The notice must include the following:

- The phrase "demand letter under s. 627.736";
- The name of the insured;
- A copy of assignment of rights, if the matter is brought by a third-party;
- The claim number or policy number;
- And the following, if the circumstances apply:
  - Name of the medical provider (for treatment, services, accommodations, or supplies);
  - An itemized statement specifying:[47]
    - The exact amount;
    - Date of treatment, service, or accommodation; and
    - The type of benefit due;
  - If the demand letter is responding to a withdrawal of pre-payment for services:
    - A copy of the insurer's notice of withdrawal; and
    - An itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

The demand letter must be sent by certified or registered U.S. Mail, return receipt requested.[48] The letter must be sent to the name and address designated by the insurer for receipt of PIP demand letters pursuant to statute.[49]

Civil actions on the claim detailed in the demand letter are barred if the insurer pays the overdue claim, along with a 10 percent penalty and interest (not to exceed $250), within 30 days of receipt of the letter.[50] The insurer is not liable for the claimant's attorney fees if they timely comply with these requirements.

The filing of a demand letter tolls the applicable statute of limitations for 30 days.

Effect of the bill

The bill applies the demand letter requirements to any related relief (i.e., attorney fees), in addition to the PIP benefits sought by the claimant. It also adds the following requirements:

- The demand letter must also include:
  - A copy of the signed assignment of rights, if the claimant is not the insured;
    - The assignment must predate the treatment, service, or accommodation, as applicable;
  - Both the claim number and the policy number, rather than one or the other;
  - The itemized statement must:
    - Identify each treatment, service, or accommodation provided to the insured;

[47] A completed claim form [CMS 1500 form, UB-92 form (HICFA 1450), or form adopted by the Office of Insurance Regulation, as applicable] or lost wage statement previously submitted to the insurer may be used as the itemized statement. S. 627.736(10)(b)3., F.S. The CMS 1500 form and UB-92 form (HICFA 1450) are standardized medical billing forms.

[48] The postal costs may be recovered from the insurer, if they are requested in the demand letter. S. 627.736(10)(c), F.S.

[49] "Each licensed insurer, whether domestic, foreign, or alien, shall file with the [Office of Insurance Regulation] the name and address of the designated person to whom notices must be sent which the [Office of Insurance Regulation] shall make available on its Internet website. The name and address on file with the [Office of Insurance Regulation] pursuant to s. 624.422 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made." S. 627.736(10)(c), F.S.

[50] In cases where the letter responded to a withdrawal of pre-payment of services, the action is barred if the insurer provides a written agreement within 30 days to pay for such services and to pay a 10 percent penalty (not to exceed $250) when the insurer pays for the future treatment. S. 627.736(10)(d), F.S.

- Include the CPT Code;[51]
- Specify, using the previously billed line items, the:
  - Date of each treatment, service, or accommodation;
  - Amount charged;
  - Amount paid; and
  - Include the CMS 1500 form, UB-92 (HICFA 1450 form), or OIR form, as applicable;
- Identify all billed line items in dispute;
- State:
  - The factual or legal basis for the contention that the underpayment or non-payment is incorrect;
  - The amount that the claimant contends the insurer is required to pay, including penalties, interest, and postage due.

If the insurer has denied reimbursement because the policy's benefits have been exhausted, the notice must include:

- Any treatment, service, or accommodation that is alleged to be improperly paid;
- The amount of the alleged improper payment; and
- The amount the insurer is required to pay to resolve the dispute.

If the claimant contends that the insured sustained an emergency medical condition, the demand letter must include documentation of the emergency medical condition from a medical provider allowed under the PIP law to determine such conditions.[52]

The demand letter must comply with the statutory requirements. If it does not comply:

- The penalty and interest due under the statute are waived; and
- The civil action is barred.

The civil action is also barred if the insurer timely issues full payment within the time allowed to respond to the demand letter with payment, or if the civil action is for a claim for non-payment or underpayment that was not identified on a demand letter. If the claimant files a civil action that is barred, the insurer may recover reasonable legal fees, costs, and disbursements related to the defense of the barred action from the claimant and their counsel.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.155, F.S., relating to civil remedy.
Section 2: Amends s. 624.422, F.S., relating to service of process; appointment of Chief Financial Officer as process agent.
Section 3: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.
Section 4. Providing an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[51] A CPT code is a procedure identification code listed in *Current Procedural Terminology*, published by the American Medical Association. https://www.ama-assn.org/practice-management/cpt (last visited Feb. 28, 2020).
[52] Under PIP, non-emergency benefits are limited to $2,500, while emergency medical conditions may increase coverage to $10,000.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If litigation rates and costs are reduced, consumers may experience lower insurance costs.

The change in maximum allowable charges for certain PIP medical providers may result in lower reimbursements.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill neither authorizes nor requires the adoption of rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On lines 46-48, the bill states "[t]he 60 days shall begin tolling when the department receives an e-mail notice of receipt from the insurer."

- "…60 days shall begin tolling…" – It is unclear which 60-day period is referenced. There are two, a 60-day cure period, which begins running upon filing of a civil remedy notice, and a 60-day statute of limitation tolling period, which begins at the same time. Context tends to indicate that the referenced period is the 60-day cure period referenced in this same paragraph; however, the use of the term "tolling" indicates that the period is not running. This is contrary to the purpose of the paragraph. If this sentence is intended to mean the statute of limitation tolling period, then it may avoid confusion by specifically referencing the statute of limitation or move the sentence to the paragraph that includes the tolling provision. If the intent is to begin the 60-day cure period only upon receipt of an email notice indicating that the insurer has received the notice, then the word "tolling" should be replaced with the word "running." If the intent is to both begin the 60-day cure period and the tolling of the statute of limitation upon receipt of the email notice, then additional amendments should be made to provide such clarity.

- "…when the department receives an e-mail notice of receipt from the insurer…" –

- The bill does not require the insurer to issue a delivery receipt to DFS; rather, it is presumed that such a receipt will be issued in all instances by the insurer. Sending delivery and read receipts in certain email systems is a user configurable feature.[53] Absent such a requirement, the 60-day cure period would not begin in an instance where DFS does not receive a notice of receipt of delivery from the insurer. If the intent of the bill is to create a definitive beginning date for the 60-day cure period, then either creating a requirement for the insurer to issue such a receipt or beginning the 60-day period upon DFS forwarding the notice to the statutorily required insurer email address designated for this purpose could avoid confusion over periods that determine or limit important rights.
- This creates a disparity between the start of the 60-day cure period and the 60-day statute of limitation tolling period. The 60-day cure period begins when DFS receives a notice of receipt from the insurer. The 60-day statute of limitation tolling period begins when the insurer receives the email from DFS forwarding the notice. This is not the same thing and could lead to the tolling period expiring before the cure period. If the notice was filed at or near the expiration of the statute of limitation and DFS received the delivery receipt after the end of the statute of limitations expired, then the claimant's rights could be impacted if the insurer waited to act until after the tolling period and the statute of limitations expired, but the cure period was still running.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 28, 2020, the Insurance & Banking Subcommittee considered a proposed committee substitute, adopted two amendments, and reported the bill favorably as a committee substitute. The following changes were made to the bill:

- **Deletions**
  - Removed two sections of the bill (ss. 6 and 25) that proposed to create certain requirements for disposition of insurance proceeds.

- **Additions:**
  - Added a new section to the bill (s. 25) to include chapter. 647, F.S., within the Florida Insurance Code. This clarifies that the regulation of travel insurance will continue to be done within the Code.

- **Revisions:**
  - Motor Vehicle Insurance Online Verification System –
    - Incorporated technical and clarifying changes identified by the Department of Highway Safety & Motor Vehicles; and
    - Made the development and implementation of the Motor Vehicle Insurance Online Verification System and the associated task force contingent upon receiving a specific appropriation, which could occur this Session or in the future.
  - Travel Insurance – made several revisions to conform the travel insurance related portions of the bill to the structure of the Florida Insurance Code.

On Tuesday, February 18, 2020, the Appropriations Committee adopted three amendments and reported the bill favorably as a committee substitute for committee substitute. The amendments deleted the following from the bill:

- Sections related to the establishment of the motor vehicle insurance verification system.
- Requirements for law enforcement to use the verification system.
- The creation of the Motor Vehicle Insurance Online Verification Task Force.
- Effective date for the insurance verification system and task force being subject to an appropriation.
- Requirement for the continued reporting of workers' compensation carriers that enter receivership.

[53] https://www.makeuseof.com/tag/turn-off-read-receipts-outlook/ (last visited Feb. 29, 2020). https://social.technet.microsoft.com/Forums/exchange/en-US/ee5a2146-7db6-45e2-928e-6fcc811de270/i-want-to-stop-read-and-delivery-receipts-request-for-outgoing-messages-on-exchange-2010?forum=exchangesvradminlegacy (last visited Feb. 29, 2020).

On February 27, 2020, the Commerce Committee considered a proposed committee substitute, adopted two amendments, and reported the bill favorably as a committee substitute. The following changes were made to the bill:

Deletions:

The bill no longer includes the following provisions:

- **Hurricane Catastrophe Fund –** Allows insurers to recover the value of force-placed coverage, if different than last reported value of coverage
- **Motor Vehicle Insurance –** Prohibits cancellation of policy in first 30 days, rather than first 60, to align with 2019 change requiring prepayment of only one-month's premium, rather than two-month's premium.
- **Travel Insurance –** Incorporates the NAIC model act into the Florida Insurance Code.
- **Surplus Lines Agent Affidavits –** Eliminates unnecessary affidavits of due diligence.
- **Agent Licensing –** Allows general lines agents and personal lines agents to sell service agreements and warranty contracts without requiring an additional license for that purpose.

Additions:

- **Civil Remedies against Insurers**
  - Bar to Civil Remedy
    - Creates a bar to bad faith claims over intended benefits for 3rd party claimants
      - If there is a single claimant:
        - No bad faith claim allowed if insurer tenders policy limits anytime from the date of loss up until the end of the 60-day cure period.
      - If there are multiple claimants:
        - No bad faith claim allowed if insurer tenders policy limits to the clerk of the court during one of two specified periods (claimants are then brought into court through an interpleader action and the court determines the claimants' rights/shares).
  - Civil Remedy Notice (CRN) (applies to all CRNs, not just bad faith claims)
    - The insurer must designate an email address for delivery of the CRN.
    - The claimant must file the CRN with DFS and DFS must forward it to the insurer at the designated address.
    - The 60-day cure period begins upon delivery of the forwarded CRN to the insurer.
  - Claimant's Good Faith Requirement
    - The claimant, the claimant's or insured's representative, and the insured are required to:
      - Act in good faith in:
        - Furnishing claim information;
        - Making demands;
        - Setting deadlines; and
        - Settlement attempts.[54]
  - New Insurer Defense
    - If the claimant or the claimant's representative or the insured fail to make good faith efforts to cooperate in the insurer's claim investigation, then none of them may be able to pursue a bad faith against the insurer.

- **Motor Vehicle Insurance**
  - PIP Medical Reimbursement
    - Changes the maximum allowable medical charges for emergency services and care provided in a hospital, for both the hospital and a physician's or dentist's care and services provided in the hospital, from 75 percent of usual and customary charges to 200 percent of Medicare.
  - PIP Demand Letter (pre-suit notice)
    - Requires compliance with statutory pre-suit notice content.
    - Increases specificity of items and amounts disputed.
    - Requires proof of an emergency medical condition, if applicable.

[54] This does not create a separate cause of action.

- Prohibits a lawsuit for an overdue medical reimbursement, if the:
  - Pre-suit notice is not compliant with statute.
  - Insurer has issued full payment.
  - Claimant asserts a claim not included in the pre-suit notice.
- Allows award of attorney fees and costs if an insurer obtains dismissal of the lawsuit for reasons specified above.

The staff analysis has been updated to reflect the committee substitute.