A bill to be entitled

An act relating to motor vehicle insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; amending s. 400.991, F.S.; requiring that an application for licensure or exemption from licensure as a health care clinic include a specified 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 relating to the Florida Motor Vehicle Medical Care Coverage Law is a fraudulent insurance act under certain conditions; amending s. 627.736, F.S.; providing limitations on attorney fees for certain actions under the Florida Motor Vehicle No-Fault Law; specifying that the limitations on attorney fee awards does not limit the attorney fees an insured may pay her or his attorney; creating s. 627.748, F.S.; designating specified provisions as the Florida Motor Vehicle No-Fault Medical Care Coverage Law; providing legislative findings; creating s. 627.7481, F.S.; providing purposes; creating s. 627.74811, F.S.; providing legislative intent that provisions, schedules, or procedures are to be given full force and effect regardless of their express inclusion in insurer forms; creating s. 627.7482, F.S.; providing definitions; creating s. 627.7483, F.S.; requiring

every owner or registrant of a motor vehicle required to be registered and licensed in this state to maintain specified security; providing exceptions; requiring every nonresident owner or registrant of a motor vehicle that has been physically present within this state for a specified period to maintain security; specifying means by which such security is provided; providing an exemption; creating s. 627.7484, F.S.; providing requirements for filing and maintaining proof of security; providing penalties; creating s. 627.7485, F.S.; requiring that insurance policies provide medical care coverage to specified persons; providing limits of coverage; specifying limits for medical, disability, and death benefits; providing restrictions on insurers with respect to provision of required benefits; authorizing insurers writing motor vehicle liability insurance to offer additional first-party motor vehicle coverages; prohibiting requiring purchase of other motor vehicle coverage as a condition for providing such benefits; prohibiting insurers from requiring the purchase of property damage liability insurance exceeding a specified amount in conjunction with medical care coverage insurance; providing that failure to comply with specified availability requirements constitutes an unfair method of competition or an unfair or deceptive act or practice; providing penalties; specifying benefits an insurer may exclude; providing

procedure with respect to such exclusions; specifying when benefits are due from an insurer; prohibiting insurers from obtaining liens on recovery of special damages in tort claims for medical care coverage benefits; providing that benefits under the Florida Motor Vehicle No-Fault Medical Care Coverage Law are subject to the Medicaid program in specified circumstances; requiring that an insurer repay any benefits covered by the Medicaid program within a specified period; requiring that an insurer provide a claimant an opportunity to revise claims that contain errors; specifying when benefits are overdue; requiring insurers to hold a specified amount of benefits in reserve for a certain time for the payment of providers; providing for interest on overdue payments; providing for tolling the time period in which medical care coverage benefits are required to be paid when the insurer has reasonable belief that fraud has been committed; specifying injuries for which an insurer must pay medical care coverage benefits; disallowing benefits to an insured who has committed insurance fraud; providing that a person or entity lawfully rendering treatment to an injured person for a bodily injury covered by medical care coverage may charge only a reasonable amount for services and care; providing that the insurer may pay such charges directly to the person or entity lawfully rendering such treatment; providing limits on such

charges; providing for determination of reasonableness of charges; providing that payments made by an insurer pursuant to the schedule of maximum charges, or for lesser amounts billed by providers, are considered reasonable; establishing a schedule of maximum charges; specifying that reimbursement under a schedule of maximum charges that is based on Medicare is to be calculated under the applicable Medicare schedule in effect on a specified date each year; authorizing insurers to use all Medicare coding policies and CMS payment methodologies in determining reimbursement under a schedule of maximum charges that is Medicare-based; establishing limits on specified services and care; providing conditions under which an insurer or insured is not required to pay a claim or charges; requiring the Department of Health to adopt, by rule, a list of diagnostic tests deemed not to be medically necessary and to periodically revise the list; providing procedures and requirements with respect to statements of and bills for charges for emergency services and care; directing the Financial Services Commission to adopt by rule a disclosure and acknowledgment form to be countersigned by claimants upon receipt of medical services; providing procedures and requirements with respect to investigation of claims of improper billing by a physician or other medical provider; prohibiting insurers from systematically downcoding with intent to deny

reimbursement; requiring insureds to comply with all terms of the medical care coverage policy, including submission to examinations under oath; limiting the scope of questioning during such examinations under oath; providing that compliance with policy terms is a condition precedent to the receipt of medical care coverage benefits; providing that it is an unfair method of competition or an unfair or deceptive trade practice for an insurer, as a general business practice, to request examinations under oath without a reasonable basis; providing for insurers to inspect the physical premises of providers seeking payment of medical care coverage benefits; providing that when an insured fails to appear for two or more mental or physical examinations, the medical care coverage carrier is not liable for subsequent medical care coverage benefits; creating a rebuttable presumption that an insured's failure to appear for two examinations is an unreasonable refusal to appear; creating an attorney fee cap; prohibiting the use of contingency risk multipliers in calculating attorney fee awards; requiring that an insurer must be provided with written notice of an intent to initiate litigation as a condition precedent to filing any action for benefits; providing requirements with respect to a demand letter; providing procedures and requirements with respect to payment of an overdue claim; providing for the tolling of the time period

for an action against an insurer; providing that failure to pay valid claims with specified frequency constitutes an unfair or deceptive trade practice; providing penalties; providing circumstances under which an insurer has a cause of action; providing for fraud advisory notice; requiring that all claims related to the same health care provider for the same injured person be brought in one action unless good cause is shown; authorizing the electronic transmission of notices and communications under certain conditions; creating s. 627.7486, F.S.; providing an exemption from tort liability for certain damages in legal actions under the Florida Motor Vehicle No-Fault Medical Care Coverage Law in certain circumstances; providing for recovery of tort damages in certain circumstances; providing for motions to dismiss action on specified grounds; prohibiting the award of punitive damages; creating s. 627.7487, F.S.; providing for optional deductibles and limitations of coverage for medical care coverage policies; requiring a specified notice to policyholders; creating s. 627.7488, F.S.; requiring the commission to adopt by rule a form for the notification of insureds of their right to receive medical care coverage benefits; specifying contents of such notice; providing requirements for the mailing or delivery of such notice; creating s. 627.7489, F.S.; providing for mandatory joinder of specified claims; creating s.

627.749, F.S.; providing for an insurer's right of reimbursement for medical care benefits paid to a person injured by a commercial motor vehicle under specified circumstances; providing an exception; creating s. 627.7491, F.S.; providing for application of the Florida Motor Vehicle No-Fault Medical Care Coverage Law; providing for requirements for forms and rates for policies issued or renewed on or after a specified date; requiring a specified notice to existing policyholders; amending ss. 316.646, 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032, 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.8405, 627.915, 628.909, 705.184, and 713.78, F.S.; conforming provisions; 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 applications or other documents relating to licensure as a health care clinic; conforming provisions; providing a directive to the Division of Statutory Revision; providing applicability; providing for severability; providing effective dates.

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

Section 1. Effective May 1, 2012, subsection (1) of section 316.066, Florida Statutes, is amended to read:

316.066 Written reports of crashes.—

(1)(a) A Florida Traffic Crash Report must~~, Long Form is required to~~ be completed and submitted to the entities specified in paragraph (e) ~~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 or personal injury.~~

~~2. Involved a violation of s. 316.061(1) or s. 316.193~~.

(b) ~~In every crash for which a Florida Traffic Crash Report, Long Form is not required by this section, the law enforcement officer may complete a short-form crash report or provide a driver exchange-of-information form to be completed by each party involved in the crash.~~ 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, each clearly identified as being either a driver or a passenger and specifying the vehicle in which each person was a driver or 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) 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.

(d) The driver of a vehicle that was in any manner involved in a crash resulting in damage to any vehicle or other property in an amount of $500 or more which 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 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.

(e) All ~~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 (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 Medical Care Coverage Law commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for medical care coverage benefits knowing that the payee knowingly submitted such application or document commits insurance fraud as defined in s. 817.234, Florida Statutes.

Section 3. Subsection (1) of section 626.989, Florida Statutes, is amended to read:

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

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

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

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

2. Knowingly submits:

a. A false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400 with an intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle Medical Care Coverage Law.

b. A claim for payment or other benefit pursuant to an insurance policy under the Florida Motor Vehicle Medical Care Coverage 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 4. Effective upon this act becoming a law, subsection (8) of section 627.736, Florida Statutes, is amended to read:

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

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—

(a) For legal actions commenced on or after the effective date of this act, with respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, ~~the provisions of~~ s. 627.428 applies ~~shall apply~~, except as provided in paragraph (b) and subsections (10) and (15) and except that any attorney fees recovered are limited to the lesser of the actual fee incurred based upon a rate for attorney services not to exceed $200 per billable hour or:

1. For any disputed amount of less than $500, 15 times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $5,000.

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

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

Fees incurred in litigating or quantifying the amount of fees due to the prevailing party under ss. 627.730-627.7405 are not recoverable.

(b) Notwithstanding s. 627.428, the attorney fees recovered under ss. 627.730-627.7405 shall be calculated without regard to any contingency risk multiplier.

(c) This subsection does not limit the attorney fees an insured may pay her or his attorney.

Section 5. Section 627.748, Florida Statutes, is created to read:

627.748 Florida Motor Vehicle Medical Care Coverage Law; legislative findings.—

(1) SHORT TITLE.—Sections 627.748-627.7491 may be cited as the "Florida Motor Vehicle Medical Care Coverage Law."

(2) LEGISLATIVE FINDINGS.—

(a) The Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, was intended to deliver medically necessary and appropriate medical care promptly, without regard to fault, and without undue litigation or other associated costs. This intent has been frustrated at significant cost and harm to consumers by fraud, inappropriate treatment, overutilization of medical services, inflated charges, and other abusive practices.

(b) Personal injury protection fraud has become pervasive. Widespread fraud has been documented by a statewide grand jury

("Report on Insurance Fraud Related to Personal Injury Protection" by the Fifteenth Statewide Grand Jury, 2000), the Insurance Consumer Advocate ("Report on Florida Motor Vehicle No-Fault Insurance," December 2011), and the Office of Insurance Regulation ("Report on Review of the 2011 Personal Injury Protection Data Call, April 11, 2011) as well as numerous media reports and other publications ("Suspicious Staged Accident Claims Soar in Florida," National Insurance Crime Bureau, 2010). Since 2009, no-fault fraud has cost Florida motorists and their insurers nearly $1.3 billion.

(c) Personal injury protection premiums have risen to unacceptable levels as a result of fraud and abuse, significantly impacting the ability of average families to maintain coverage mandated by law. Based on current trends, it is anticipated that personal injury protection premiums will double every 3 years.

(d) Personal injury protection insurance carrier losses from fraud and abuse are increasing faster than the rise in premiums, threatening the availability of personal injury protection coverage within this state. From 2008 to 2010, personal injury protection benefits paid by insurers increased by 70 percent, from $1.43 billion to $2.37 billion.

(e) Significant reforms must be enacted to curtail the level of fraudulent activity within no-fault motor vehicle insurance to preserve the affordability and availability of coverage within this state, particularly with respect to overutilization of certain treatment and procedures. Reform measures must also be adopted to address the proliferation of

litigation and the concomitant costs associated with the increasing number of lawsuits.

(f) Ensuring the availability and affordability of no-fault motor vehicle insurance by requiring medical care coverage is an overwhelming public necessity and provides a commensurate benefit. Moreover, deterrence and prevention of fraud and abuse are matters of great public interest and of importance to public health, safety, and welfare.

Section 6. Section 627.7481, Florida Statutes, is created to read:

627.7481 Purposes.—The purposes of ss. 627.748-627.7491 are to provide, without regard to fault, for emergency services and care, services and care for injuries arising from motor vehicle accidents, prescribed followup care, funeral benefits, and disability insurance benefits; to require motor vehicle insurance that secures such benefits for motor vehicles required to be registered in this state; and, with respect to motor vehicle accidents, to provide a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience.

Section 7. Section 627.74811, Florida Statutes, is created to read:

627.74811 Effect of law on medical care coverage policies.—The provisions, schedules, and procedures authorized in ss. 627.748-627.7491 shall be implemented by insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Medical Care Coverage Law. The Legislature intends that these provisions, schedules, and procedures have full force and effect regardless of their express inclusion in an insurance policy

form, and a specific provision, schedule, or procedure authorized in ss. 627.748-627.7491 will govern 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 of the applicable fee schedules in order to implement and apply such provisions, schedules, or procedures.

Section 8. Section 627.7482, Florida Statutes, is created to read:

627.7482 Definitions.—As used in ss. 627.748-627.7491, the term:

(1) "Ambulatory surgical center" means a facility that, at the time services or treatment were rendered, was licensed pursuant to s. 395.003.

(2) "Broker" means any person not licensed under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this subsection, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease but does not include a part-time lessee. For purposes of this subsection, the term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed; a debt collection agency; an entity that has

contracted with the insurer to obtain a discounted rate; a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment; or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under part X of chapter 400;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for medical care coverage patients is on a temporary basis not to exceed 30 days in a 12-month period and is necessitated by:

1. Repair or maintenance of existing 100-percent-owned medical equipment;

2. The pending arrival and installation of newly purchased or replacement 100-percent-owned medical equipment; or

3. A determination by the medical director or clinical director that open-style medical equipment is medically necessary for the performance of tests or procedures for patients due to a patient's physical size or claustrophobia. The leased medical equipment may not be used by patients who are not patients of the registered clinic for medical treatment of services.

However, the 30-day period provided in this paragraph may be extended for an additional 60 days as applicable to magnetic

resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234.

(3) "Certify" means to swear or attest to a fact being true or accurately represented in a writing.

(4) "Emergency medical condition" means:

(a) 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:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(5) "Emergency services and care" means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care,

treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(6) "Hospital" means a facility that, at the time services or treatment was rendered, was licensed under chapter 395.

(7) "Knowingly" means having actual knowledge of information; acting in deliberate ignorance of the truth or falsity of the information; or acting in reckless disregard of the information. Proof of specific intent to defraud is not required.

(8) "Lawful" or "lawfully" means in substantial compliance with all relevant applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.

(9) "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(c) Not primarily for the convenience of the patient, physician, or other health care provider.

(10) "Motor vehicle" means any self-propelled vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of this state and any trailer or semitrailer designed for use with such vehicle and

includes:

(a) A "private passenger motor vehicle," which is any motor vehicle that is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup truck, panel truck, van, camper, or motor home type.

(b) A "commercial motor vehicle," which is any motor vehicle that is not a private passenger motor vehicle.

The term "motor vehicle" does not include a mobile home or any motor vehicle that is used in mass transit, other than public school transportation; is designed to transport more than five passengers exclusive of the operator of the motor vehicle; and is owned by a municipality, a transit authority, or a political subdivision of the state.

(11) "Named insured" means a person, usually the owner of a motor vehicle, identified in a policy by name as the insured under the policy.

(12) "Owner," with respect to a motor vehicle, means a person who holds the legal title to a motor vehicle or, if a motor vehicle is the subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, the debtor or lessee of the motor vehicle.

(13) "Properly completed" means providing truthful, substantially complete, and substantially accurate responses as to all material elements to each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as otherwise

agreed to by the parties.

(14) "Relative residing in the insured's household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, regardless of whether she or he is temporarily living elsewhere.

(15) "Unbundling" means separating treatment or services that would be properly billed under one billing code into two or more billing codes, resulting in a payment amount greater than would be paid using one billing code.

(16) "Upcoding" means using a billing code to describe treatment or services in a manner that would result in a payment amount greater than would be paid using a billing code that accurately describes such treatment or services. The term does not include an otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

Section 9. Section 627.7483, Florida Statutes, is created to read:

627.7483 Required security.—

(1)(a) Every owner or registrant of a motor vehicle, other than a motor vehicle used as a school bus as defined in s. 1006.25 or a limousine, required to be registered and licensed in this state shall maintain security as described in subsection (3) continuously throughout the registration or licensing period.

(b) Paragraph (a) does not apply to an owner or registrant of a motor vehicle used as a taxicab, but such owner or registrant shall maintain security as required under s. 324.032(1), and s. 627.7486 does not apply to any such motor vehicle.

(2) Every nonresident owner or registrant of a motor vehicle that, whether operated or not operated, has been physically present within this state for more than 90 days during the preceding 365 days shall thereafter maintain security as described in subsection (3) continuously while such motor vehicle is physically present within this state.

(3) Security required by this section shall be provided:

(a) By an insurance policy delivered or issued for delivery in this state by an authorized or eligible motor vehicle liability insurer which provides the benefits and exemptions contained in ss. 627.748-627.7491. Any policy of insurance represented or sold as providing the security required under this section shall be deemed to provide insurance for the payment of the required benefits; or

(b) By any other method authorized by s. 324.031(2), (3), or (4) and approved by the Department of Highway Safety and Motor Vehicles as affording security equivalent to that afforded by a policy of insurance or by self-insuring as authorized by s. 768.28(16). The person filing such security shall have all of the obligations and rights of an insurer under ss. 627.748-627.7491.

(4) An owner of a motor vehicle for which security is required by this section who fails to have such security in

effect at the time of an accident is not immune from tort liability and is personally liable for the payment of benefits under s. 627.7485. With respect to such benefits, such an owner has all of the rights and obligations of an insurer under ss. 627.748-627.7491.

(5) In addition to other persons who are not required to provide security as required under this section and s. 324.022, the owner or registrant of a motor vehicle is exempt from such requirements if she or he is a member of the United States Armed Forces and is called to or on active duty outside the United States in an emergency situation. The exemption provided by this subsection applies only while the member of the armed forces is on such active duty outside the United States and while the motor vehicle covered by the security required by this section and s. 324.022 is not operated by any person. Upon receipt of a written request by the insured to whom the exemption provided in this subsection applies, the insurer shall cancel the coverages and return any unearned premium or suspend the security required by this section and s. 324.022. Notwithstanding s. 324.0221(2), the Department of Highway Safety and Motor Vehicles may not suspend the registration or operator's license of any owner or registrant of a motor vehicle during the time she or he qualifies for an exemption under this subsection. Any owner or registrant of a motor vehicle who qualifies for an exemption under this subsection shall immediately notify the department prior to and at the end of the expiration of the exemption.

Section 10. Section 627.7484, Florida Statutes, is created to read:

627.7484 Proof of security; security requirements; penalties.—

(1) The provisions of chapter 324 that pertain to the method of giving and maintaining proof of financial responsibility and that govern and define a motor vehicle liability policy apply to filing and maintaining proof of security required by ss. 627.748-627.7491.

(2) Any person who:

(a) Gives information required in a report or otherwise as provided for in ss. 627.748-627.7491, knowing or having reason to believe that such information is false;

(b) Forges or, without authority, signs any evidence of proof of security; or

(c) Files, or offers for filing, any such evidence of proof, knowing or having reason to believe that it is forged or signed without authority

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 11. Section 627.7485, Florida Statutes, is created to read:

627.7485 Required medical care coverage benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.7483 must provide medical care coverage to the named insured, relatives residing in the insured's household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons

struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(f), to a limit of $10,000 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.—Up to a limit of $10,000, 80 percent of all reasonable expenses as follows:

1. Emergency transport and treatment rendered by an ambulance provider licensed under part III of chapter 401 within 24 hours after the motor vehicle accident.

2. Emergency services and care rendered in a hospital within 7 days after the motor vehicle accident.

3. Services and care rendered when an insured is admitted to a hospital within 7 days after the motor vehicle accident.

4. Emergency services and care rendered to an insured in a hospital who is determined more than 7 days after the motor vehicle accident to have an emergency medical condition related to the initial medical diagnosis made in a hospital and arising from the motor vehicle accident.

5. If the insured receives services and care pursuant to subparagraph 2., subparagraph 3., or subparagraph 4., subsequent services and care directly related to the determination of an emergency medical condition and medical diagnosis arising from the motor vehicle accident, subject to the following:

a. The medical diagnosis and the determination of an emergency medical condition shall be rendered in a hospital and rendered by a physician licensed under chapter 458, by an

osteopathic physician licensed under chapter 459, by a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464; and

b. The care and services shall be rendered by a physician licensed under chapter 458, an osteopathic physician licensed under 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.

6. If the insured receives services and care pursuant to subparagraph 2., subparagraph 3., subparagraph 4., or subparagraph 5., all medically necessary medical, surgical, dental, nursing, or diagnostic ancillary services, hospital or ambulatory surgical center services, durable medical equipment, prosthetics, or orthotics and supplies.

For purposes of ss. 627.748-627.7491, a determination pursuant to this paragraph that an emergency medical condition exists is presumed to be correct unless rebutted by clear and convincing evidence to the contrary.

(b) Medical benefits.—Up to a limit of $1,500, 80 percent of all reasonable expenses as follows:

1. Services and care rendered within 7 days after the motor vehicle accident by a physician licensed under chapter 458, an osteopathic physician licensed under 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.

2. If the insured receives services and care pursuant to subparagraph 1., subsequent services and care rendered by a provider listed in subparagraph 1. and directly related to the medical diagnosis arising from the motor vehicle accident.

3. All medically necessary medical, surgical, dental, nursing, or diagnostic ancillary services, hospital or ambulatory surgical center services, durable medical equipment, prosthetics, or orthotics and supplies.

Payment of benefits under this paragraph shall occur only if a person has been determined in a hospital not to have an emergency medical condition or the person did not present herself or himself at a hospital but received treatment from a provider identified in subparagraph 1. within 7 days after the motor vehicle accident.

(c) 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 her or his household. All disability benefits payable under this paragraph shall be paid not less than every 2 weeks.

(d) Death benefits.—Death benefits of $5,000 per

individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer shall pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the benefits required by this section, and no such insurer may 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 medical care coverage insurance. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice, as determined by the office, shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. Any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those that may be afforded elsewhere in the insurance code. An insurer writing motor vehicle liability insurance may offer insureds additional first-party motor

vehicle coverages.

(2) AUTHORIZED EXCLUSIONS.—Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the insured's household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person if such person's conduct contributed to her or his injury under either of the following circumstances:

1. Causing injury to herself or himself intentionally; or

2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any medical care coverage benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.—No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for medical care coverage benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to

bring suit under ss. 627.748-627.7491, or her or his legal representative, shall have no right to recover any damages for which medical care coverage benefits are paid or payable. The plaintiff may prove all of her or his special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, may not award damages for medical care coverage benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff may not recover such special damages for medical care coverage benefits paid or payable.

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.748-627.7491 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred that are covered by the policy issued under ss. 627.748-627.7491. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.748-627.7491 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 for which the policy affords the security required by ss. 627.748-627.7491.

(b) Medical care coverage benefits paid pursuant to this section are overdue if not paid within 30 days after the insurer is furnished written notice of the fact and amount of a covered loss. However:

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

2. If 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; however, this does not limit the introduction of evidence at trial. The insurer 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 shall provide at the time of the partial payment or rejection an

itemized specification or explanation of benefits of the specified error. Upon receiving the specification or explanation, the person making the claim has, at the person's option and without waiving any other legal remedy for payment, 15 days to submit a revised claim, and the revised claim shall be considered a timely submission of written notice of a claim.

4. Notwithstanding the fact that written notice has been furnished to the insurer, a payment may not be deemed overdue 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 considered made on the date a draft or other valid instrument that 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 medical care coverage benefits, the insurer must reserve $5,000 of medical care coverage benefits for payment to physicians licensed under chapter 458 or chapter

459, dentists licensed under chapter 466, physician assistants licensed under chapter 458 or chapter 459, or advanced registered nurse practitioners licensed under chapter 464 who provide medical care coverage pursuant to subparagraphs (1)(a)2. and 3. The amount required to be held in reserve may be used only to pay claims from such medical providers 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 a claim from such medical provider for medical care coverage benefits may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of medical care coverage benefits 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 a medical provider eligible to receive payment of medical care coverage benefits to the extent that the medical care coverage 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 quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of the covered loss. Interest shall be due at the time payment of the overdue claim is made.

(e) 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. The insurer then has an additional 60 days, beginning at the end of the initial 30-day period, to conduct its fraud investigation. Notwithstanding subsection (9), no later than 90 days after the submission of the claim, the insurer must either deny 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.

(f) The insurer of the owner of a motor vehicle shall pay medical care coverage benefits for accidental bodily injury:

1. 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. 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. Sustained by a relative of the owner residing in the insured's household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not herself or himself the owner of a motor vehicle with respect to which security is required under ss. 627.748-627.7491.

4. 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, provided the injured person is not herself or himself:

a. The owner of a motor vehicle for which security is required under ss. 627.748-627.7491; or

b. Entitled to medical care coverage benefits from the insurer of the owner or owners of such a motor vehicle.

(g) If two or more insurers are liable to pay medical care coverage benefits for the same injury to any one person, the maximum amount payable shall be as specified in subsection (1), and any insurer paying the benefits 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.

(h) 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, as determined by the office.

(i) Benefits are not due or payable to or on behalf of an insured, claimant, medical provider, or attorney if the insured, claimant, medical provider, or attorney has:

1. Submitted a false material statement, document, record, or bill;

2. Submitted false material information; or

3. Otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989.

A claimant who violates this paragraph is not entitled to any medical care coverage benefits or payment for any bills and services, regardless of whether a portion of the claim may be legitimate. However, a medical provider who does not violate this paragraph may not be denied benefits solely due to the violation by another claimant.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) Any person or entity lawfully rendering treatment to an injured person for a bodily injury covered by medical care coverage insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services, treatment, and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or entity lawfully rendering such treatment, if the insured receiving such treatment or her or his 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 of the knowledge of the insured or her or his guardian. However, such a charge may not exceed the amount the person or entity customarily charges for like services, treatment, or supplies. When determining whether a charge for a particular service, treatment, or supply is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance

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

1. When a health care provider or entity bills an insurer in an amount less than indicated in the following schedule of maximum charges and the insurer pays the amount billed, the payment shall be considered reasonable. However, a payment made by an insurer that limits reimbursement to 80 percent of the following schedule of maximum charges is considered reasonable:

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

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 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 or ambulatory surgical center providing the outpatient services.

f. For all other medical services, treatment, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B; for

medical services, treatment, supplies, and care provided by clinical laboratories, 200 percent of the allowable amount under Medicare Part B; and for durable medical equipment, the amount contained in the Durable Medical Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule of Medicare Part B. However, if such services, treatment, or supplies, and care are not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder that are in effect at the time such services, treatment, supplies, or care are provided. Services, treatment, or supplies that are not reimbursable under Medicare or workers' compensation are not required to be reimbursed by the insurer.

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

3. Subparagraph 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. must reimburse a provider who lawfully provided care or treatment under the scope of her or his license regardless of whether such provider is 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, nothing in subparagraph 1. prohibits an insurer from using any and all Medicare coding policies and Centers for Medicare and Medicaid Services (CMS) payment methodologies, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, treatment, supplies, or care.

4. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, treatment, 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 medical care coverage insurance due to the coinsurance amount or maximum policy limits.

(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 material 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 billing codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed billing codes, without affecting the right of the provider to dispute the change by the insurer; however, before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding or make a reasonable good faith effort to do so as documented in the insurer's file; or

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 her or his 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 medical care coverage benefits under this section. The list 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 shall be based on lack of demonstrated medical value and a level

of general acceptance by the relevant provider community and may not be dependent 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 any diagnostic test deemed not medically necessary 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 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 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.

2. If, however, the insured fails to furnish the provider with the correct name and address of the insured's medical care coverage 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.

3. For emergency services and care 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 may not be considered to have been furnished with notice of the amount of the covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or a copy thereof, that specifically identifies the place of service as a hospital emergency department or an ambulance in accordance with billing standards recognized by the Health Care Finance Administration.

4. Each notice of insured's rights under s. 627.7488 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.—Florida 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 person or entity shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 form, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include

on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may 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 may not be considered to have been furnished with notice of the amount of the covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the time the initial treatment or service is provided, each person or entity providing medical services upon which a claim for medical care coverage benefits is based shall require an insured person or her or his guardian to execute a disclosure and acknowledgment form that reflects at a minimum that:

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

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

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

d. The person or entity rendering services for which payment is being claimed explained the services to the insured or her or his guardian.

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 person or entity rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured or her or his guardian so that the insured or her or his guardian countersigns the form with informed consent.

3. Countersignature by the insured or her or his guardian is not required for the reading of diagnostic tests or other services 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 her or his 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. This disclosure and acknowledgment form is not required

for services billed by a provider for emergency services and care 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 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 January 1, 2013. Until the rule is final, the provider may use a form of its own that otherwise complies with the requirements of this paragraph.

8. As used in this paragraph, the term "countersigned" means bearing 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. This paragraph applies 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, that is consistent with the services being rendered to the patient as claimed. The 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 whether

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 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, 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.

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

(a) An insured seeking benefits under ss. 627.748-627.7491, including omnibus insureds, 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.

(b) Every employer shall, if a request is made by an insurer providing medical care coverage under ss. 627.748-627.7491 against whom a claim has been made, furnish 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.

(c) Every person or entity providing, before or after bodily injury upon which a claim for medical care coverage 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, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request and furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, her or his or its records regarding such history, condition, treatment, dates, and costs of treatment; however,

this does not limit the introduction of evidence at trial. Such sworn statement 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."

No cause of action for violation of the physician-patient privilege or invasion of the right of privacy may be permitted against any person or entity complying with this paragraph. 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 is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. 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, as determined by the office, is engaging in an unfair trade practice under the insurance code. Section 626.989(4)(d) applies to the sharing of information related to reviews and

examinations conducted pursuant to this section.

(d) In the event of 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 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, 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.

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

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

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

(a) Whenever the mental or physical condition of an injured person covered by medical care coverage insurance is material to any claim that has been or may be made for past or future medical care coverage 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, such examination shall be conducted in an area of the closest proximity to the insured's residence. Medical care coverage insurers are authorized to include reasonable provisions in medical care coverage insurance policies for mental and physical examination of those claiming medical care coverage insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the medical care coverage insurance unless the insurer first obtains a valid report by a physician located in this state 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, is factually supported by the examination and treatment records, if reviewed, and 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 medical care coverage, 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 paragraph 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 her or him a copy of every written report concerning the examination rendered by an examining physician, at least one of which 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 her or him or her or his 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 she or he may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, her or him with respect to the same mental or physical condition. If a person unreasonably refuses to submit to or fails to appear at an examination, the medical care coverage insurer is no longer liable for subsequent medical care coverage benefits. Refusal or failure to appear for two examinations raises a rebuttable presumption that such refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.—

(a) With respect to any dispute under ss. 627.748-627.7491 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, s. 627.428 applies, except as provided in paragraph (b) and subsections (9) and (13) and except that any attorney fees recovered are limited to the lesser of the actual fee incurred based upon a rate for attorney services not to exceed $200 per billable hour or:

1. For any disputed amount of less than $500, 15 times any disputed amount recovered by the attorney under ss. 627.748-627.7491, not to exceed $5,000.

2. For any disputed amount of $500 or more and less than $5,000, 10 times any disputed amount recovered by the attorney under ss. 627.748-627.7491, not to exceed $10,000.

3. For any disputed amount of $5,000 or more and up to $10,000, 5 times any disputed amount recovered by the attorney under ss. 627.748-627.7491, not to exceed $15,000.

Fees incurred in litigating or quantifying the amount of fees due to the prevailing party under ss. 627.748-627.7491 are not recoverable.

(b) Notwithstanding s. 627.428, the attorney fees recovered under ss. 627.748-627.7491 shall be calculated without regard to any contingency risk multiplier.

(c) Nothing in this subsection limits the attorney fees an insured may pay her or his attorney.

(9) 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. 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 required shall state that it is a "demand letter under s. 627.7485(9), F.S.," and shall state with specificity:

1. The name of the insured upon whom 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. If so requested by the claimant in the notice, such postal costs shall be reimbursed by the insurer 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 person to whom notices pursuant to this subsection shall be sent, which the office shall make available on its website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection 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 not payable in any subsequent action. For purposes of this paragraph, payment or the insurer's agreement shall be considered 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 fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this paragraph.

(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, as determined by the office, 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.

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

(a) If an insurer fails to pay valid claims for medical care coverage with such frequency so as to indicate a general business practice, as determined by the office, 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 with respect thereto.

(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.

(11) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to, insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054,

associated with a claim for medical care coverage benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768 and attorney fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to, insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for medical care coverage benefits in accordance with this section.

(12) FRAUD ADVISORY NOTICE.—Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing medical care coverage or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and, if such conduct has taken place, it should be immediately reported to the Division of Insurance Fraud.

(13) ALL CLAIMS BROUGHT IN A SINGLE ACTION.—In any civil action to recover medical care coverage benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney fees to the claimant.

(14) 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. 627.748-627.7491 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 627.7486, Florida Statutes, is created to read:

627.7486 Tort exemption; limitation on right to damages; punitive damages.—

(1) Every owner, registrant, operator, or occupant of a motor vehicle for which security has been provided as required by ss. 627.748-627.7491, and every person or organization legally responsible for her or his acts or omissions, is exempt from tort liability for damages because of bodily injury, sickness, or disease arising out of the ownership, operation, maintenance, or use of such motor vehicle in this state to the extent that the benefits described in s. 627.7485(1) are payable

for such injury, or would be payable but for any exclusion authorized by ss. 627.748-627.7491, under any insurance policy or other method of security complying with s. 627.7483, or by an owner personally liable under s. 627.7483 for the payment of such benefits, unless a person is entitled to maintain an action for pain, suffering, mental anguish, and inconvenience for such injury under subsection (2).

(2) In any action of tort brought against the owner, registrant, operator, or occupant of a motor vehicle for which security has been provided as required by ss. 627.748-627.7491, or against any person or organization legally responsible for her or his acts or omissions, a plaintiff may recover damages in tort for pain, suffering, mental anguish, and inconvenience because of bodily injury, sickness, or disease arising out of the ownership, maintenance, operation, or use of such motor vehicle only in the event that the injury or disease consists in whole or in part of:

(a) Significant and permanent loss of an important bodily function;

(b) Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement;

(c) Significant and permanent scarring or disfigurement; or

(d) Death.

(3) When a defendant in a proceeding brought pursuant to ss. 627.748-627.7491 questions whether the plaintiff has met the requirements of subsection (2), the defendant may file an appropriate motion with the court, and the court shall, on a

one-time basis only, 30 days before the date set for the trial or the pretrial hearing, whichever is first, by examining the pleadings and the evidence before it, ascertain whether the plaintiff will be able to submit some evidence that the plaintiff will meet the requirements of subsection (2). If the court finds that the plaintiff will not be able to submit such evidence, the court shall dismiss the plaintiff's claim without prejudice.

(4) In any action brought against a motor vehicle liability insurer for damages in excess of its policy limits, no claim for punitive damages shall be allowed.

Section 13. Section 627.7487, Florida Statutes, is created to read:

627.7487 Medical care coverage; optional limitations; deductibles.—

(1) The named insured may elect a deductible or modified coverage or combination thereof to apply to the named insured alone or to the named insured and dependent relatives residing in the insured's household but may not elect a deductible or modified coverage to apply to any other person covered under the policy.

(2) An insurer shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles in amounts of $250, $500, and $1,000. The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.7485. After the deductible is met, each insured is eligible to receive up to $10,000 in total benefits described in s. 627.7485(1). However, this subsection may not be

applied to reduce the amount of any benefits received in accordance with s. 627.7485(1)(d).

(3) An insurer shall offer coverage wherein, at the election of the named insured, the benefits for loss of gross income and loss of earning capacity described in s. 627.7485(1)(c) shall be excluded.

(4) The named insured may not be prevented from electing a deductible under subsection (2) and modified coverage under subsection (3). Each election made by the named insured under this section shall result in an appropriate reduction of premium associated with that election.

(5) All such offers shall be made in clear and unambiguous language at the time the initial application is taken and before each annual renewal and shall indicate that a premium reduction will result from each election. At the option of the insurer, such requirement may be met by using forms of notice approved by the office or by providing the following notice in 10-point type in the insurer's application for initial issuance of a policy of motor vehicle insurance and the insurer's annual notice of renewal premium:

For medical care coverage insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage

exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

Section 14. Section 627.7488, Florida Statutes, is created to read:

627.7488 Notice of insured's rights.—

(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive medical care coverage under the Florida Motor Vehicle No-Fault Medical Care Coverage Law. Such notice shall include:

(a) A description of the benefits provided by medical care coverage insurance, including, but not limited to, the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions from and limitations on medical care coverage benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, penalties and interest that may be imposed on insurers for failure to make timely payments of benefits, and rights of parties regarding disputes as to benefits.

(b) An advisory informing insureds that:

1. Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

2. Pursuant to s. 627.7485(5)(e)1.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.

(c) A notice that solicitation of a person injured in a motor vehicle crash for purposes of filing medical care coverage or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and, if such conduct has taken place, it should be immediately reported to the Division of Insurance Fraud.

(2) Each insurer issuing a policy in this state providing medical care coverage benefits must mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving from the insured notice of a motor vehicle accident or claim involving personal injury to an insured who is covered under the policy. The office may allow an insurer additional time, not to exceed 30 days, to provide the notice specified in subsection (1) upon a showing by the insurer that an emergency justifies an extension of time.

(3) The notice required by this section does not alter or modify the terms of the insurance contract or other requirements of ss. 627.748-627.7491.

Section 15. Section 627.7489, Florida Statutes, is created to read:

627.7489 Mandatory joinder of derivative claim.—In any action brought pursuant to s. 627.7486 claiming personal injuries, all claims arising out of the plaintiff's injuries, including all derivative claims, shall be brought together,

unless good cause is shown why such claims should be brought separately.

Section 16. Section 627.749, Florida Statutes, is created to read:

627.749 Insurers' right of reimbursement.—

(1) Notwithstanding any other provisions of ss. 627.748-627.7491, any insurer providing medical care coverage benefits on a private passenger motor vehicle shall have, to the extent of any medical care coverage 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) For purposes of this section, an owner or registrant identified in s. 627.7483(1)(b) is not liable for a right of reimbursement.

Section 17. Section 627.7491, Florida Statutes, is created to read:

627.7491 Application of the Florida Motor Vehicle No-Fault Medical Care Coverage Law.—

(1) All forms and rates for policies issued or renewed on or after December 1, 2012, for purposes of maintaining security as required by s. 627.7483 must reflect ss. 627.748-627.7491 and must be approved by the office prior to their use.

(2) The coverage provided under ss. 627.748-627.7491 shall

supersede and replace the coverage provided under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, for any motor vehicle insurance policy issued or renewed on or after the effective date of this act.

(3) After the effective date of this act, insurers must provide notice of the Florida Motor Vehicle No-Fault Medical Care Coverage Law to existing policyholders at least 30 days before the policy expiration date and to applicants for no-fault coverage upon receipt of the application. The notice is not subject to approval by the office and must clearly inform the policyholder or applicant of the following:

(a) That no-fault motor vehicle insurance requirements are governed by the Florida Motor Vehicle No-Fault Medical Care Coverage Law and must provide an explanation of medical care coverage. Current policyholders, with respect to the initial renewal after the effective date of this act, must also be provided with an explanation of differences between their current policies and the coverage provided under medical care coverage policies.

(b) That failure to maintain required medical care coverage and $10,000 in property damage liability coverage may result in suspension of the policyholder's driver license and vehicle registration by the State of Florida.

(c) The name and telephone number of a person to contact with any questions she or he may have.

Section 18. Subsection (1) of section 316.646, Florida Statutes, is amended to read:

316.646 Security required; proof of security and display

thereof; dismissal of cases.—

(1) Any person required by s. 324.022 to maintain property damage liability security, required by s. 324.023 to maintain liability security for bodily injury or death, or required by s. 627.733 or s. 627.7483 to maintain personal injury protection security or medical care coverage security, as applicable, on a motor vehicle shall have in his or her immediate possession at all times while operating such motor vehicle proper proof of maintenance of the required security. Such proof shall be a uniform proof-of-insurance card in a form prescribed by the department, a valid insurance policy, an insurance policy binder, a certificate of insurance, or such other proof as may be prescribed by the department.

Section 19. Paragraph (b) of subsection (2) of section 318.18, Florida Statutes, is amended to read:

318.18 Amount of penalties.—The penalties required for a noncriminal disposition pursuant to s. 318.14 or a criminal offense listed in s. 318.17 are as follows:

(2) Thirty dollars for all nonmoving traffic violations and:

(b) For all violations of ss. 320.0605, 320.07(1), 322.065, and 322.15(1). Any person who is cited for a violation of s. 320.07(1) shall be charged a delinquent fee pursuant to s. 320.07(4).

1. If a person who is cited for a violation of s. 320.0605 or s. 320.07 can show proof of having a valid registration at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10. A person who finds

it impossible or impractical to obtain a valid registration certificate must submit an affidavit detailing the reasons for the impossibility or impracticality. The reasons may include, but are not limited to, the fact that the vehicle was sold, stolen, or destroyed; that the state in which the vehicle is registered does not issue a certificate of registration; or that the vehicle is owned by another person.

2. If a person who is cited for a violation of s. 322.03, s. 322.065, or s. 322.15 can show a driver ~~driver's~~ license issued to him or her and valid at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10.

3. If a person who is cited for a violation of s. 316.646 can show proof of security as required by s. 627.733 or s. 627.7483, as applicable, issued to the person and valid at the time of arrest, the clerk of the court may dismiss the case and may assess a dismissal fee of up to $10. A person who finds it impossible or impractical to obtain proof of security must submit an affidavit detailing the reasons for the impracticality. The reasons may include, but are not limited to, the fact that the vehicle has since been sold, stolen, or destroyed; that the owner or registrant of the vehicle is not required by s. 627.733 or s. 627.7483 to maintain personal injury protection insurance or medical care coverage insurance, as applicable; or that the vehicle is owned by another person.

Section 20. Paragraphs (a) and (d) of subsection (5) of section 320.02, Florida Statutes, are amended to read:

320.02 Registration required; application for

registration; forms.—

(5)(a) Proof that personal injury protection benefits or medical care coverage benefits, as applicable, have been purchased when required under s. 627.733 or s. 627.7483, as applicable, that property damage liability coverage has been purchased as required under s. 324.022, that bodily injury or death coverage has been purchased if required under s. 324.023, and that combined bodily liability insurance and property damage liability insurance have been purchased when required under s. 627.7415 shall be provided in the manner prescribed by law by the applicant at the time of application for registration of any motor vehicle that is subject to such requirements. The issuing agent shall refuse to issue registration if such proof of purchase is not provided. Insurers shall furnish uniform proof-of-purchase cards in a form prescribed by the department and shall include the name of the insured's insurance company, the coverage identification number, and the make, year, and vehicle identification number of the vehicle insured. The card shall contain a statement notifying the applicant of the penalty specified in s. 316.646(4). The card or insurance policy, insurance policy binder, or certificate of insurance or a photocopy of any of these; an affidavit containing the name of the insured's insurance company, the insured's policy number, and the make and year of the vehicle insured; or such other proof as may be prescribed by the department shall constitute sufficient proof of purchase. If an affidavit is provided as proof, it shall be in substantially the following form:

Under penalty of perjury, I ...(Name of insured)... do hereby certify that I have ...(Personal Injury Protection or Medical Care Coverage, as applicable, Property Damage Liability, and, when required, Bodily Injury Liability)... Insurance currently in effect with ...(Name of insurance company)... under ...(policy number)... covering ...(make, year, and vehicle identification number of vehicle).... ...(Signature of Insured)...

Such affidavit shall include the following warning:

WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A VEHICLE REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER FLORIDA LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT IS SUBJECT TO PROSECUTION.

When an application is made through a licensed motor vehicle dealer as required in s. 319.23, the original or a photostatic copy of such card, insurance policy, insurance policy binder, or certificate of insurance or the original affidavit from the insured shall be forwarded by the dealer to the tax collector of the county or the Department of Highway Safety and Motor Vehicles for processing. By executing the aforesaid affidavit, no licensed motor vehicle dealer will be liable in damages for any inadequacy, insufficiency, or falsification of any statement contained therein. A card shall also indicate the existence of any bodily injury liability insurance voluntarily purchased.

(d) The verifying of proof of personal injury protection insurance or medical care coverage insurance, as applicable, proof of property damage liability insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance and the issuance or failure to issue the motor vehicle registration under ~~the provisions of~~ this chapter may not be construed in any court as a warranty of the reliability or accuracy of the evidence of such proof. Neither the department nor any tax collector is liable in damages for any inadequacy, insufficiency, falsification, or unauthorized modification of any item of the proof of personal injury protection insurance or medical care coverage insurance, as applicable, proof of property damage liability insurance, proof of combined bodily liability insurance and property damage liability insurance, or proof of financial responsibility insurance prior to, during, or subsequent to the verification of the proof. The issuance of a motor vehicle registration does not constitute prima facie evidence or a presumption of insurance coverage.

Section 21. Paragraph (b) of subsection (1) of section 320.0609, Florida Statutes, is amended to read:

320.0609 Transfer and exchange of registration license plates; transfer fee.—

(1)

(b) The transfer of a license plate from a vehicle disposed of to a newly acquired vehicle does not constitute a new registration. The application for transfer shall be accepted without requiring proof of personal injury protection insurance

or medical care coverage insurance, as applicable, or liability insurance.

Section 22. Subsection (3) of section 320.27, Florida Statutes, is amended to read:

320.27 Motor vehicle dealers.—

(3) APPLICATION AND FEE.—The application for the license shall be in such form as may be prescribed by the department and shall be subject to such rules with respect thereto as may be so prescribed by it. Such application shall be verified by oath or affirmation and shall contain a full statement of the name and birth date of the person or persons applying therefor; the name of the firm or copartnership, with the names and places of residence of all members thereof, if such applicant is a firm or copartnership; the names and places of residence of the principal officers, if the applicant is a body corporate or other artificial body; the name of the state under whose laws the corporation is organized; the present and former place or places of residence of the applicant; and prior business in which the applicant has been engaged and the location thereof. Such application shall describe the exact location of the place of business and shall state whether the place of business is owned by the applicant and when acquired, or, if leased, a true copy of the lease shall be attached to the application. The applicant shall certify that the location provides an adequately equipped office and is not a residence; that the location affords sufficient unoccupied space upon and within which adequately to store all motor vehicles offered and displayed for sale; and that the location is a suitable place where the

applicant can in good faith carry on such business and keep and maintain books, records, and files necessary to conduct such business, which will be available at all reasonable hours to inspection by the department or any of its inspectors or other employees. The applicant shall certify that the business of a motor vehicle dealer is the principal business which shall be conducted at that location. Such application shall contain a statement that the applicant is either franchised by a manufacturer of motor vehicles, in which case the name of each motor vehicle that the applicant is franchised to sell shall be included, or an independent (nonfranchised) motor vehicle dealer. Such application shall contain such other relevant information as may be required by the department, including evidence that the applicant is insured under a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy, which shall include, at a minimum, $25,000 combined single-limit liability coverage including bodily injury and property damage protection and $10,000 personal injury protection or medical care coverage, as applicable. Franchise dealers must submit a garage liability insurance policy, and all other dealers must submit a garage liability insurance policy or a general liability insurance policy coupled with a business automobile policy. Such policy shall be for the license period, and evidence of a new or continued policy shall be delivered to the department at the beginning of each license period. Upon making initial application, the applicant shall pay to the department a fee of $300 in addition to any other fees now required by law; upon

making a subsequent renewal application, the applicant shall pay to the department a fee of $75 in addition to any other fees now required by law. Upon making an application for a change of location, the person shall pay a fee of $50 in addition to any other fees now required by law. The department shall, in the case of every application for initial licensure, verify whether certain facts set forth in the application are true. Each applicant, general partner in the case of a partnership, or corporate officer and director in the case of a corporate applicant, must file a set of fingerprints with the department for the purpose of determining any prior criminal record or any outstanding warrants. The department shall submit the fingerprints to the Department of Law Enforcement for state processing and forwarding to the Federal Bureau of Investigation for federal processing. The actual cost of state and federal processing shall be borne by the applicant and is in addition to the fee for licensure. The department may issue a license to an applicant pending the results of the fingerprint investigation, which license is fully revocable if the department subsequently determines that any facts set forth in the application are not true or correctly represented.

Section 23. Paragraph (j) of subsection (3) of section 320.771, Florida Statutes, is amended to read:

320.771 License required of recreational vehicle dealers.—

(3) APPLICATION.—The application for such license shall be in the form prescribed by the department and subject to such rules as may be prescribed by it. The application shall be verified by oath or affirmation and shall contain:

(j) A statement that the applicant is insured under a garage liability insurance policy, which shall include, at a minimum, $25,000 combined single-limit liability coverage, including bodily injury and property damage protection, and $10,000 personal injury protection or medical care coverage, as applicable, if the applicant is to be licensed as a dealer in, or intends to sell, recreational vehicles.

The department shall, if it deems necessary, cause an investigation to be made to ascertain if the facts set forth in the application are true and shall not issue a license to the applicant until it is satisfied that the facts set forth in the application are true.

Section 24. Subsection (1) of section 322.251, Florida Statutes, is amended to read:

322.251 Notice of cancellation, suspension, revocation, or disqualification of license.—

(1) All orders of cancellation, suspension, revocation, or disqualification issued under ~~the provisions of~~ this chapter, chapter 318, chapter 324, ~~or~~ ss. 627.732-627.734, or ss. 627.748-627.7491 shall be given either by personal delivery thereof to the licensee whose license is being canceled, suspended, revoked, or disqualified or by deposit in the United States mail in an envelope, first class, postage prepaid, addressed to the licensee at his or her last known mailing address furnished to the department. Such mailing by the department constitutes notification, and any failure by the person to receive the mailed order will not affect or stay the

effective date or term of the cancellation, suspension, revocation, or disqualification of the licensee's driving privilege.

Section 25. Paragraph (a) of subsection (8) of section 322.34, Florida Statutes, is amended to read:

322.34 Driving while license suspended, revoked, canceled, or disqualified.—

(8)(a) Upon the arrest of a person for the offense of driving while the person's driver ~~driver's~~ license or driving privilege is suspended or revoked, the arresting officer shall determine:

1. Whether the person's driver ~~driver's~~ license is suspended or revoked.

2. Whether the person's driver ~~driver's~~ license has remained suspended or revoked since a conviction for the offense of driving with a suspended or revoked license.

3. Whether the suspension or revocation was made under s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, relating to failure to maintain required security, or under s. 322.264, relating to habitual traffic offenders.

4. Whether the driver is the registered owner or coowner of the vehicle.

Section 26. Subsection (1) and paragraph (c) of subsection (9) of section 324.021, Florida Statutes, are amended to read:

324.021 Definitions; minimum insurance required.—The following words and phrases when used in this chapter shall, for the purpose of this chapter, have the meanings respectively ascribed to them in this section, except in those instances

where the context clearly indicates a different meaning:

(1) MOTOR VEHICLE.—Every self-propelled vehicle which is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use with such vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle which is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped. However, the term "motor vehicle" does ~~shall~~ not include any motor vehicle as defined in s. 627.732(3) or s. 627.7482, as applicable, when the owner of such vehicle has complied with the requirements of ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable, inclusive, unless ~~the provisions of~~ s. 324.051 applies ~~apply~~; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

(9) OWNER; OWNER/LESSOR.—

(c) Application.—

1. The limits on liability in subparagraphs (b)2. and 3. do not apply to an owner of motor vehicles that are used for commercial activity in the owner's ordinary course of business, other than a rental company that rents or leases motor vehicles. For purposes of this paragraph, the term "rental company" includes only an entity that is engaged in the business of renting or leasing motor vehicles to the general public and that rents or leases a majority of its motor vehicles to persons with no direct or indirect affiliation with the rental company. The term also includes a motor vehicle dealer that provides temporary replacement vehicles to its customers for up to 10

days. The term "rental company" also includes:

a. A related rental or leasing company that is a subsidiary of the same parent company as that of the renting or leasing company that rented or leased the vehicle.

b. The holder of a motor vehicle title or an equity interest in a motor vehicle title if the title or equity interest is held pursuant to or to facilitate an asset-backed securitization of a fleet of motor vehicles used solely in the business of renting or leasing motor vehicles to the general public and under the dominion and control of a rental company, as described in this subparagraph, in the operation of such rental company's business.

2. Furthermore, with respect to commercial motor vehicles as defined in s. 627.732 or s. 627.7482, as applicable, the limits on liability in subparagraphs (b)2. and 3. do not apply if, at the time of the incident, the commercial motor vehicle is being used in the transportation of materials found to be hazardous for the purposes of the Hazardous Materials Transportation Authorization Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq., and that is required pursuant to such act to carry placards warning others of the hazardous cargo, unless at the time of lease or rental either:

a. The lessee indicates in writing that the vehicle will not be used to transport materials found to be hazardous for the purposes of the Hazardous Materials Transportation Authorization Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq.; or

b. The lessee or other operator of the commercial motor vehicle has in effect insurance with limits of at least

$5,000,000 combined property damage and bodily injury liability.

Section 27. Section 324.0221, Florida Statutes, is amended to read:

324.0221 Reports by insurers to the department; suspension of driver ~~driver's~~ license and vehicle registrations; reinstatement.—

(1)(a) Each insurer that has issued a policy providing personal injury protection or medical care coverage or property damage liability coverage shall report the renewal, cancellation, or nonrenewal thereof to the department within 45 days after the effective date of each renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing personal injury protection or medical care coverage or property damage liability coverage to a named insured not previously insured by the insurer during that calendar year, the insurer shall report the issuance of the new policy to the department within 30 days. The report shall be in the form and format and contain any information required by the department and must be provided in a format that is compatible with the data processing capabilities of the department. The department may adopt rules regarding the form and documentation required. Failure by an insurer to file proper reports with the department as required by this subsection or rules adopted with respect to the requirements of this subsection constitutes a violation of the Florida Insurance Code. These records shall be used by the department only for enforcement and regulatory purposes, including the generation by the department of data regarding compliance by owners of motor vehicles with the requirements for financial responsibility

coverage.

(b) With respect to an insurance policy providing personal injury protection or medical care coverage or property damage liability coverage, each insurer shall notify the named insured, or the first-named insured in the case of a commercial fleet policy, in writing that any cancellation or nonrenewal of the policy will be reported by the insurer to the department. The notice must also inform the named insured that failure to maintain personal injury protection or medical care coverage and property damage liability coverage on a motor vehicle when required by law may result in the loss of registration and driving privileges in this state and inform the named insured of the amount of the reinstatement fees required by this section. This notice is for informational purposes only, and an insurer is not civilly liable for failing to provide this notice.

(2) The department shall suspend, after due notice and an opportunity to be heard, the registration and driver ~~driver's~~ license of any owner or registrant of a motor vehicle with respect to which security is required under s. ~~ss.~~ 324.022 and either s. 627.733 or s. 627.7483, as applicable, upon:

(a) The department's records showing that the owner or registrant of such motor vehicle did not have in full force and effect when required security that complies with the requirements of s. ~~ss.~~ 324.022 and either s. 627.733 or s. 627.7483, as applicable; or

(b) Notification by the insurer to the department, in a form approved by the department, of cancellation or termination of the required security.

(3) An operator or owner whose driver ~~driver's~~ license or registration has been suspended under this section or s. 316.646 may effect its reinstatement upon compliance with the requirements of this section and upon payment to the department of a nonrefundable reinstatement fee of $150 for the first reinstatement. The reinstatement fee is $250 for the second reinstatement and $500 for each subsequent reinstatement during the 3 years following the first reinstatement. A person reinstating her or his insurance under this subsection must also secure noncancelable coverage as described in ss. 324.021(8), 324.023, and 627.7275(2) and present to the appropriate person proof that the coverage is in force on a form adopted by the department, and such proof shall be maintained for 2 years. If the person does not have a second reinstatement within 3 years after her or his initial reinstatement, the reinstatement fee is $150 for the first reinstatement after that 3-year period. If a person's license and registration are suspended under this section or s. 316.646, only one reinstatement fee must be paid to reinstate the license and the registration. All fees shall be collected by the department at the time of reinstatement. The department shall issue proper receipts for such fees and shall promptly deposit those fees in the Highway Safety Operating Trust Fund. One-third of the fees collected under this subsection shall be distributed from the Highway Safety Operating Trust Fund to the local governmental entity or state agency that employed the law enforcement officer seizing the license plate pursuant to s. 324.201. The funds may be used by the local governmental entity or state agency for any authorized

purpose.

Section 28. Paragraph (a) of subsection (1) of section 324.032, Florida Statutes, is amended to read:

324.032 Manner of proving financial responsibility; for-hire passenger transportation vehicles.—Notwithstanding the provisions of s. 324.031:

(1)(a) A person who is either the owner or a lessee required to maintain insurance under s. 627.733(1)(b) or s. 627.7483(1)(b), as applicable, and who operates one or more taxicabs, limousines, jitneys, or any other for-hire passenger transportation vehicles may prove financial responsibility by furnishing satisfactory evidence of holding a motor vehicle liability policy, but with minimum limits of $125,000/250,000/50,000.

Upon request by the department, the applicant must provide the department at the applicant's principal place of business in this state access to the applicant's underlying financial information and financial statements that provide the basis of the certified public accountant's certification. The applicant shall reimburse the requesting department for all reasonable costs incurred by it in reviewing the supporting information. The maximum amount of self-insurance permissible under this subsection is $300,000 and must be stated on a per-occurrence basis, and the applicant shall maintain adequate excess insurance issued by an authorized or eligible insurer licensed or approved by the Office of Insurance Regulation. All risks self-insured shall remain with the owner or lessee providing it,

and the risks are not transferable to any other person, unless a policy complying with subsection (1) is obtained.

Section 29. Subsection (2) of section 324.171, Florida Statutes, is amended to read:

324.171 Self-insurer.—

(2) The self-insurance certificate shall provide limits of liability insurance in the amounts specified under s. 324.021(7) or s. 627.7415 and shall provide personal injury protection or medical care coverage under s. 627.733(3)(b) or s. 627.7483(3)(b), as applicable.

Section 30. Paragraph (g) of subsection (1) of section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action. If the clinic performs only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, and the American College of Radiology;

and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to all personal injury protection insurance or medical care coverage insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume the responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

Section 31. Subsection (28) of section 409.901, Florida Statutes, is amended to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(28) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the agency, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist

insurance or personal injury protection or medical care coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 32. Paragraph (f) of subsection (11) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

1. After attorney ~~attorney's~~ fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.

2. The remaining amount of the recovery shall be paid to the recipient.

3. For purposes of calculating the agency's recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal

representative shall be calculated at 25 percent of the judgment, award, or settlement.

4. Notwithstanding any provision of this section to the contrary, the agency shall be entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, medical care, personal injury protection, and casualty.

Section 33. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.—

(2) As used in this section, the terms "records owner," "health care practitioner," and "health care practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:

(k) Persons or entities practicing under s. 627.736(7) or s. 627.7485(7), as applicable.

Section 34. Paragraphs (ee) and (ff) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(ee) With respect to making a personal injury protection or a medical care coverage claim as required by s. 627.736 or s. 627.7485, respectively, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732 or s. 627.7482, as applicable.

(ff) With respect to making a personal injury protection or a medical care coverage claim as required by s. 627.736 or s. 627.7485, respectively, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

Section 35. Paragraph (o) 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:

(o) Illegal dealings in premiums; excess or reduced charges for insurance.—

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for

insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the office, and as specified in the policy; or, in cases when classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges collected from a Florida resident in excess of or less than those specified in the policy and as fixed by the insurer. This provision may ~~shall~~ not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph may ~~shall~~ not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, medical care coverage, personal injury protection, medical payment, or collision insurance or any combination thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured

was substantially at fault in the accident.

b. An insurer which imposes and collects such a surcharge or which refuses to renew such policy shall, in conjunction with the notice of premium due or notice of nonrenewal, notify the named insured that he or she is entitled to reimbursement of such amount or renewal of the policy under the conditions listed below and will subsequently reimburse him or her or renew the policy, if the named insured demonstrates that the operator involved in the accident was:

(I) Lawfully parked;

(II) Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;

(III) Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;

(IV) Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;

(V) Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving traffic violation;

(VI) Finally adjudicated not to be liable by a court of competent jurisdiction;

(VII) In receipt of a traffic citation which was dismissed or nolle prossed; or

(VIII) Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault

which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

c. In addition to the other provisions of this subparagraph, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current 3-year period. However, an insurer may nonrenew a policy for reasons other than accidents in accordance with s. 627.728. This subparagraph does not prohibit nonrenewal of a policy under which the insured has had three or more accidents, regardless of fault, during the most recent 3-year period.

4. Imposing or requesting an additional premium for, or refusing to renew, a policy for motor vehicle insurance solely because the insured committed a noncriminal traffic infraction as described in s. 318.14 unless the infraction is:

a. A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.

b. A violation of s. 316.183, when such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.

5. Upon the request of the insured, the insurer and licensed agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

6. No insurer shall impose or request an additional premium for motor vehicle insurance, cancel or refuse to issue a

policy, or refuse to renew a policy because the insured or the applicant is a handicapped or physically disabled person, so long as such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

7. No insurer may cancel or otherwise terminate any insurance contract or coverage, or require execution of a consent to rate endorsement, during the stated policy term for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. No insurer may issue a nonrenewal notice on any insurance contract or coverage, or require execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

9. No insurer shall, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

10. Imposing or requesting an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

11. No insurer shall cancel or issue a nonrenewal notice

on any insurance policy or contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

12. No insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

Section 36. Subsection (1) of section 627.06501, Florida Statutes, is amended to read:

627.06501 Insurance discounts for certain persons completing driver improvement course.—

(1) Any rate, rating schedule, or rating manual for the liability, medical care, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office may provide for an appropriate reduction in premium charges as to such coverages when the principal operator on the covered vehicle has successfully completed a driver improvement course approved and certified by the Department of Highway Safety and Motor Vehicles which is effective in reducing crash or violation rates, or both, as determined pursuant to s. 318.1451(5). Any discount, not to exceed 10 percent, used by an insurer is presumed to be appropriate unless credible data demonstrates otherwise.

Section 37. Subsection (1) of section 627.0652, Florida

Statutes, is amended to read:

627.0652 Insurance discounts for certain persons completing safety course.—

(1) Any rates, rating schedules, or rating manuals for the liability, medical care, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office shall provide for an appropriate reduction in premium charges as to such coverages when the principal operator on the covered vehicle is an insured 55 years of age or older who has successfully completed a motor vehicle accident prevention course approved by the Department of Highway Safety and Motor Vehicles. Any discount used by an insurer is presumed to be appropriate unless credible data demonstrates otherwise.

Section 38. Subsections (1) and (3) of section 627.0653, Florida Statutes, are amended to read:

627.0653 Insurance discounts for specified motor vehicle equipment.—

(1) Any rates, rating schedules, or rating manuals for the liability, medical care, personal injury protection, and collision coverages of a motor vehicle insurance policy filed with the office shall provide a premium discount if the insured vehicle is equipped with factory-installed, four-wheel antilock brakes.

(3) Any rates, rating schedules, or rating manuals for medical care coverage, personal injury protection coverage, and medical payments coverage, if offered, of a motor vehicle insurance policy filed with the office shall provide a premium discount if the insured vehicle is equipped with one or more air

bags which are factory installed.

Section 39. Section 627.4132, Florida Statutes, is amended to read:

627.4132 Stacking of coverages prohibited.—If an insured or named insured is protected by any type of motor vehicle insurance policy for liability, medical care, personal injury protection, or other coverage, the policy shall provide that the insured or named insured is protected only to the extent of the coverage she or he has on the vehicle involved in the accident. However, if none of the insured's or named insured's vehicles is involved in the accident, coverage is available only to the extent of coverage on any one of the vehicles with applicable coverage. Coverage on any other vehicles may ~~shall~~ not be added to or stacked upon that coverage. This section does not apply:

(1) To uninsured motorist coverage which is separately governed by s. 627.727.

(2) To reduce the coverage available by reason of insurance policies insuring different named insureds.

Section 40. Subsection (6) of section 627.6482, Florida Statutes, is amended to read:

627.6482 Definitions.—As used in ss. 627.648-627.6498, the term:

(6) "Health insurance" means any hospital and medical expense incurred policy, minimum premium plan, stop-loss coverage, health maintenance organization contract, prepaid health clinic contract, multiple-employer welfare arrangement contract, or fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract. The

term does not include any policy covering medical payment coverage or medical care or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, or workers' compensation.

Section 41. Section 627.7263, Florida Statutes, is amended to read:

627.7263 Rental and leasing driver ~~driver's~~ insurance to be primary; exception.—

(1) The valid and collectible liability insurance, medical care coverage insurance, or personal injury protection insurance providing coverage for the lessor of a motor vehicle for rent or lease is primary unless otherwise stated in at least 10-point type on the face of the rental or lease agreement. Such insurance is primary for the limits of liability and personal injury protection or medical care coverage as required by s. ~~ss.~~ 324.021(7) and either s. 627.736 or s. 627.7485, as applicable.

(2) If the lessee's coverage is to be primary, the rental or lease agreement must contain the following language, in at least 10-point type:

"The valid and collectible liability insurance and personal injury protection insurance or medical care coverage insurance, as applicable, of any authorized rental or leasing driver is primary for the limits of liability and personal injury protection or medical care coverage, as applicable, required by s. ~~ss.~~ 324.021(7) and either s. 627.736 or s. 627.7485, Florida Statutes, as applicable."

Section 42. Subsections (1) and (7) of section 627.727, Florida Statutes, are amended to read:

627.727 Motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.—

(1) No motor vehicle liability insurance policy which provides bodily injury liability coverage shall be delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or principally garaged in this state unless uninsured motor vehicle coverage is provided therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom. However, the coverage required under this section is not applicable when, or to the extent that, an insured named in the policy makes a written rejection of the coverage on behalf of all insureds under the policy. When a motor vehicle is leased for a period of 1 year or longer and the lessor of such vehicle, by the terms of the lease contract, provides liability coverage on the leased vehicle, the lessee of such vehicle shall have the sole privilege to reject uninsured motorist coverage or to select lower limits than the bodily injury liability limits, regardless of whether the lessor is qualified as a self-insurer pursuant to s. 324.171. Unless an insured, or lessee having the privilege of rejecting uninsured motorist coverage, requests such coverage or requests higher uninsured motorist limits in writing, the coverage or such higher uninsured motorist limits need not be

provided in or supplemental to any other policy which renews, extends, changes, supersedes, or replaces an existing policy with the same bodily injury liability limits when an insured or lessee had rejected the coverage. When an insured or lessee has initially selected limits of uninsured motorist coverage lower than her or his bodily injury liability limits, higher limits of uninsured motorist coverage need not be provided in or supplemental to any other policy which renews, extends, changes, supersedes, or replaces an existing policy with the same bodily injury liability limits unless an insured requests higher uninsured motorist coverage in writing. The rejection or selection of lower limits shall be made on a form approved by the office. The form shall fully advise the applicant of the nature of the coverage and shall state that the coverage is equal to bodily injury liability limits unless lower limits are requested or the coverage is rejected. The heading of the form shall be in 12-point bold type and shall state: "You are electing not to purchase certain valuable coverage which protects you and your family or you are purchasing uninsured motorist limits less than your bodily injury liability limits when you sign this form. Please read carefully." If this form is signed by a named insured, it will be conclusively presumed that there was an informed, knowing rejection of coverage or election of lower limits on behalf of all insureds. The insurer shall notify the named insured at least annually of her or his options as to the coverage required by this section. Such notice shall be part of, and attached to, the notice of premium, shall provide for a means to allow the insured to request such

coverage, and shall be given in a manner approved by the office. Receipt of this notice does not constitute an affirmative waiver of the insured's right to uninsured motorist coverage where the insured has not signed a selection or rejection form. The coverage described under this section shall be over and above, but may ~~shall~~ not duplicate, the benefits available to an insured under any workers' compensation law, medical care coverage or personal injury protection benefits, disability benefits law, or similar law; under any automobile medical expense coverage; under any motor vehicle liability insurance coverage; or from the owner or operator of the uninsured motor vehicle or any other person or organization jointly or severally liable together with such owner or operator for the accident; and such coverage shall cover the difference, if any, between the sum of such benefits and the damages sustained, up to the maximum amount of such coverage provided under this section. The amount of coverage available under this section may ~~shall~~ not be reduced by a setoff against any coverage, including liability insurance. Such coverage may ~~shall~~ not inure directly or indirectly to the benefit of any workers' compensation or disability benefits carrier or any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or similar law.

(7) The legal liability of an uninsured motorist coverage insurer does not include damages in tort for pain, suffering, mental anguish, and inconvenience unless the injury or disease is described in one or more of paragraphs (a)-(d) of s. 627.737(2) or one or more of paragraphs (a)-(d) of s.

627.7486(2), as applicable.

Section 43. Subsection (1) of section 627.7275, Florida Statutes, is amended to read:

627.7275 Motor vehicle liability.—

(1) A motor vehicle insurance policy providing personal injury protection as set forth in s. 627.736 or medical care coverage as set forth in s. 627.7485 may not be delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or principally garaged in this state unless the policy also provides coverage for property damage liability as required by s. 324.022.

Section 44. Paragraph (a) of subsection (1) of section 627.728, Florida Statutes, is amended to read:

627.728 Cancellations; nonrenewals.—

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

(a) "Policy" means the bodily injury and property damage liability, medical care, personal injury protection, medical payments, comprehensive, collision, and uninsured motorist coverage portions of a policy of motor vehicle insurance delivered or issued for delivery in this state:

1. Insuring a natural person as named insured or one or more related individuals resident of the same household; and

2. Insuring only a motor vehicle of the private passenger type or station wagon type which is not used as a public or livery conveyance for passengers or rented to others; or insuring any other four-wheel motor vehicle having a load capacity of 1,500 pounds or less which is not used in the

occupation, profession, or business of the insured other than farming; other than any policy issued under an automobile insurance assigned risk plan; insuring more than four automobiles; or covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

The term "policy" does not include a binder as defined in s. 627.420 unless the duration of the binder period exceeds 60 days.

Section 45. Subsection (1), paragraph (a) of subsection (5), and subsections (6) and (7) of section 627.7295, Florida Statutes, are amended to read:

627.7295 Motor vehicle insurance contracts.—

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

(a) "Policy" means a motor vehicle insurance policy that provides personal injury protection or medical care coverage, property damage liability coverage, or both.

(b) "Binder" means a binder that provides motor vehicle personal injury protection or medical care coverage and property damage liability coverage.

(5)(a) A licensed general lines agent may charge a per-policy fee not to exceed $10 to cover the administrative costs of the agent associated with selling the motor vehicle insurance policy if the policy covers only personal injury protection or medical care coverage as provided by s. 627.736 or s. 627.7485, as applicable, and property damage liability coverage as provided by s. 627.7275 and if no other insurance is sold or

issued in conjunction with or collateral to the policy. The fee is not considered part of the premium.

(6) If a motor vehicle owner's driver license, license plate, and registration have previously been suspended pursuant to s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, an insurer may cancel a new policy only as provided in s. 627.7275.

(7) A policy of private passenger motor vehicle insurance or a binder for such a policy may be initially issued in this state only if, before the effective date of such binder or policy, the insurer or agent has collected from the insured an amount equal to 2 months' premium. An insurer, agent, or premium finance company may not, directly or indirectly, take any action resulting in the insured having paid from the insured's own funds an amount less than the 2 months' premium required by this subsection. This subsection applies without regard to whether the premium is financed by a premium finance company or is paid pursuant to a periodic payment plan of an insurer or an insurance agent. This subsection does not apply if an insured or member of the insured's family is renewing or replacing a policy or a binder for such policy written by the same insurer or a member of the same insurer group. This subsection does not apply to an insurer that issues private passenger motor vehicle coverage primarily to active duty or former military personnel or their dependents. This subsection does not apply if all policy payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer payment plan from the policyholder. This subsection and subsection (4) do not apply if all policy payments to an insurer are paid pursuant to an

automatic electronic funds transfer payment plan from an agent, a managing general agent, or a premium finance company and if the policy includes, at a minimum, personal injury protection or medical care coverage pursuant to ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable; motor vehicle property damage liability pursuant to s. 627.7275; and bodily injury liability in at least the amount of $10,000 because of bodily injury to, or death of, one person in any one accident and in the amount of $20,000 because of bodily injury to, or death of, two or more persons in any one accident. This subsection and subsection (4) do not apply if an insured has had a policy in effect for at least 6 months, the insured's agent is terminated by the insurer that issued the policy, and the insured obtains coverage on the policy's renewal date with a new company through the terminated agent.

Section 46. Section 627.8405, Florida Statutes, is amended to read:

627.8405 Prohibited acts; financing companies.—No premium finance company shall, in a premium finance agreement or other agreement, finance the cost of or otherwise provide for the collection or remittance of dues, assessments, fees, or other periodic payments of money for the cost of:

(1) A membership in an automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, this definition of "automobile club" does not

include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon racecourses established and marked as such for the duration of such particular events. The words "motor vehicle" used herein have the same meaning as defined in chapter 320.

(2) An accidental death and dismemberment policy sold in combination with a personal injury protection and property damage only policy or a medical care and property damage only policy, as applicable.

(3) Any product not regulated under ~~the provisions of~~ this insurance code.

This section also applies to premium financing by any insurance agent or insurance company under part XVI. The commission shall adopt rules to assure disclosure, at the time of sale, of coverages financed with personal injury protection or medical care coverage and shall prescribe the form of such disclosure.

Section 47. Subsection (1) of section 627.915, Florida Statutes, is amended to read:

627.915 Insurer experience reporting.—

(1) Each insurer transacting private passenger automobile insurance in this state shall report certain information annually to the office. The information will be due on or before July 1 of each year. The information shall be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; medical care coverage or personal

injury protection benefits; medical payments; comprehensive and collision. The information given shall be on direct insurance writings in the state alone and shall represent total limits data. The information set forth in paragraphs (a)-(f) is applicable to voluntary private passenger and Joint Underwriting Association private passenger writings and shall be reported for each of the latest 3 calendar-accident years, with an evaluation date of March 31 of the current year. The information set forth in paragraphs (g)-(j) is applicable to voluntary private passenger writings and shall be reported on a calendar-accident year basis ultimately seven times at seven different stages of development.

(a) Premiums earned for the latest 3 calendar-accident years.

(b) Loss development factors and the historic development of those factors.

(c) Policyholder dividends incurred.

(d) Expenses for other acquisition and general expense.

(e) Expenses for agents' commissions and taxes, licenses, and fees.

(f) Profit and contingency factors as utilized in the insurer's automobile rate filings for the applicable years.

(g) Losses paid.

(h) Losses unpaid.

(i) Loss adjustment expenses paid.

(j) Loss adjustment expenses unpaid.

Section 48. Paragraph (d) of subsection (2) and paragraph (d) of subsection (3) of section 628.909, Florida Statutes, are

amended to read:

628.909 Applicability of other laws.—

(2) The following provisions of the Florida Insurance Code shall apply to captive insurers who are not industrial insured captive insurers to the extent that such provisions are not inconsistent with this part:

(d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as applicable, when no-fault coverage is provided.

(3) The following provisions of the Florida Insurance Code shall apply to industrial insured captive insurers to the extent that such provisions are not inconsistent with this part:

(d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as applicable, when no-fault coverage is provided.

Section 49. Subsections (2) and (6) and paragraphs (a), (c), and (d) of subsection (7) of section 705.184, Florida Statutes, are amended to read:

705.184 Derelict or abandoned motor vehicles on the premises of public-use airports.—

(2) The airport director or the director's designee shall contact the Department of Highway Safety and Motor Vehicles to notify that department that the airport has possession of the abandoned or derelict motor vehicle and to determine the name and address of the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and any person who has filed a lien on the motor vehicle. Within 7 business days after receipt of the information, the director or the director's designee shall send notice by certified mail,

return receipt requested, to the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle. The notice shall state the fact of possession of the motor vehicle, that charges for reasonable towing, storage, and parking fees, if any, have accrued and the amount thereof, that a lien as provided in subsection (6) will be claimed, that the lien is subject to enforcement pursuant to law, that the owner or lienholder, if any, has the right to a hearing as set forth in subsection (4), and that any motor vehicle which, at the end of 30 calendar days after receipt of the notice, has not been removed from the airport upon payment in full of all accrued charges for reasonable towing, storage, and parking fees, if any, may be disposed of as provided in s. 705.182(2)(a), (b), (d), or (e), including, but not limited to, the motor vehicle being sold free of all prior liens after 35 calendar days after the time the motor vehicle is stored if any prior liens on the motor vehicle are more than 5 years of age or after 50 calendar days after the time the motor vehicle is stored if any prior liens on the motor vehicle are 5 years of age or less.

(6) The airport pursuant to this section or, if used, a licensed independent wrecker company pursuant to s. 713.78 shall have a lien on an abandoned or derelict motor vehicle for all reasonable towing, storage, and accrued parking fees, if any, except that no storage fee shall be charged if the motor vehicle is stored less than 6 hours. As a prerequisite to perfecting a lien under this section, the airport director or the director's

designee must serve a notice in accordance with subsection (2) on the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle. If attempts to notify the owner, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, or lienholders are not successful, the requirement of notice by mail shall be considered met. Serving of the notice does not dispense with recording the claim of lien.

(7)(a) For the purpose of perfecting its lien under this section, the airport shall record a claim of lien which shall state:

1. The name and address of the airport.

2. The name of the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle.

3. The costs incurred from reasonable towing, storage, and parking fees, if any.

4. A description of the motor vehicle sufficient for identification.

(c) The claim of lien shall be sufficient if it is in substantially the following form:

CLAIM OF LIEN

State of .....

County of .....

Before me, the undersigned notary public, personally appeared

....., who was duly sworn and says that he/she is the ..... of ....., whose address is.....; and that the following described motor vehicle:
...(Description of motor vehicle)...
owned by ....., whose address is ....., has accrued $..... in fees for a reasonable tow, for storage, and for parking, if applicable; that the lienor served its notice to the owner, the insurance company insuring the motor vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, Florida Statutes, as applicable, and all persons of record claiming a lien against the motor vehicle on ...., ...(year)..., by.....
...(Signature)...
Sworn to (or affirmed) and subscribed before me this .... day of ...., ...(year)..., by ...(name of person making statement)....
...(Signature of Notary Public).....(Print, Type, or Stamp Commissioned name of Notary Public)...
Personally Known....OR Produced....as identification.

However, the negligent inclusion or omission of any information in this claim of lien which does not prejudice the owner does not constitute a default that operates to defeat an otherwise valid lien.

(d) The claim of lien shall be served on the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, when no-fault coverage is provided, and all persons of record claiming a lien against the motor vehicle. If attempts

to notify the owner, the insurance company insuring the motor vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, when no-fault coverage is provided, or lienholders are not successful, the requirement of notice by mail shall be considered met. The claim of lien shall be so served before recordation.

Section 50. Paragraphs (a), (b), and (c) of subsection (4) of section 713.78, Florida Statutes, are amended to read:

713.78 Liens for recovering, towing, or storing vehicles and vessels.—

(4)(a) Any person regularly engaged in the business of recovering, towing, or storing vehicles or vessels who comes into possession of a vehicle or vessel pursuant to subsection (2), and who claims a lien for recovery, towing, or storage services, shall give notice to the registered owner, the insurance company insuring the vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and to all persons claiming a lien thereon, as disclosed by the records in the Department of Highway Safety and Motor Vehicles or of a corresponding agency in any other state.

(b) Whenever any law enforcement agency authorizes the removal of a vehicle or vessel or whenever any towing service, garage, repair shop, or automotive service, storage, or parking place notifies the law enforcement agency of possession of a vehicle or vessel pursuant to s. 715.07(2)(a)2., the law enforcement agency of the jurisdiction where the vehicle or vessel is stored shall contact the Department of Highway Safety and Motor Vehicles, or the appropriate agency of the state of

registration, if known, within 24 hours through the medium of electronic communications, giving the full description of the vehicle or vessel. Upon receipt of the full description of the vehicle or vessel, the department shall search its files to determine the owner's name, the insurance company insuring the vehicle or vessel, and whether any person has filed a lien upon the vehicle or vessel as provided in s. 319.27(2) and (3) and notify the applicable law enforcement agency within 72 hours. The person in charge of the towing service, garage, repair shop, or automotive service, storage, or parking place shall obtain such information from the applicable law enforcement agency within 5 days after the date of storage and shall give notice pursuant to paragraph (a). The department may release the insurance company information to the requestor notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable.

(c) Notice by certified mail, return receipt requested, shall be sent within 7 business days after the date of storage of the vehicle or vessel to the registered owner, the insurance company insuring the vehicle notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the vehicle or vessel. It shall state the fact of possession of the vehicle or vessel, that a lien as provided in subsection (2) is claimed, that charges have accrued and the amount thereof, that the lien is subject to enforcement pursuant to law, and that the owner or lienholder, if any, has the right to a hearing as set forth in subsection (5), and that any vehicle or vessel which remains unclaimed, or for which the charges for recovery, towing, or storage services

remain unpaid, may be sold free of all prior liens after 35 days if the vehicle or vessel is more than 3 years of age or after 50 days if the vehicle or vessel is 3 years of age or less.

Section 51. Paragraph (a) of subsection (1), paragraph (c) of subsection (7), paragraphs (a), (b), and (c) of subsection (8), and subsection (9) 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 medical care coverage insurance policy if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400.

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(7) or s. 627.7485(7), as applicable, ~~s. 627.736(8)~~ or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) It is unlawful for any person intending to defraud any other person to solicit or cause to be solicited any business from a person involved in a motor vehicle accident for the purpose of making, adjusting, or settling motor vehicle tort claims or claims for personal injury protection or medical care coverage benefits required by s. 627.736 or s. 627.7485, as applicable. Any person who violates ~~the provisions of~~ this paragraph commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

(b) A person may not solicit or cause to be solicited any business from a person involved in a motor vehicle accident by any means of communication other than advertising directed to the public for the purpose of making motor vehicle tort claims or claims for personal injury protection or medical care coverage benefits required by s. 627.736 or s. 627.7485, as applicable, within 60 days after the occurrence of the motor vehicle accident. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A lawyer, health care practitioner as defined in s. 456.001, or owner or medical director of a clinic required to be licensed pursuant to s. 400.9905 may not, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, solicit or cause to be solicited any business from a person involved in a motor vehicle accident by means of in person or telephone contact at the person's residence, for the

purpose of making motor vehicle tort claims or claims for personal injury protection or medical care coverage benefits required by s. 627.736 or s. 627.7485, as applicable. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(9) A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash or a scheme to create documentation of a motor vehicle crash that did not occur for the purpose of making motor vehicle tort claims or claims for personal injury protection or medical care coverage benefits as required by s. 627.736 or s. 627.7485, as applicable. Any person who violates this subsection commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

Section 52. The Division of Statutory Revision is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date this act becomes a law.

Section 53. 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 this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 54. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon

this act becoming a law, this act shall take effect December 1, 2012, and shall apply to policies issued or renewed on or after that date.