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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/02/2012	.	
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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Delete lines 299 - 1509
and insert:
Notwithstanding this subsection, an entity shall be deemed a clinic and must be licensed under this part in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law, unless exempted under s. 627.736(5)(h), or under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law, unless exempted under s. 627.7485(1)(a)2.

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



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13 400.991 License requirements; background screenings;
14 prohibitions.—

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

18
19 INSURANCE FRAUD NOTICE.—A person who knowingly submits
20 a false, misleading, or fraudulent application or
21 other document when applying for licensure as a health
22 care clinic, seeking an exemption from licensure as a
23 health care clinic, or demonstrating compliance with
24 part X of chapter 400, Florida Statutes, with the
25 intent to use the license, exemption from licensure,
26 or demonstration of compliance to provide services or
27 seek reimbursement under the Florida Motor Vehicle No-
28 Fault Law or the Florida Motor Vehicle No-Fault
29 Emergency Care Coverage Law, commits a fraudulent
30 insurance act, as defined in s. 626.989, Florida
31 Statutes. A person who presents a claim for personal
32 injury protection or emergency care coverage benefits
33 knowing that the payee knowingly submitted such health
34 care clinic application or document, commits insurance
35 fraud, as defined in s. 817.234, Florida Statutes.

36
37 Section 4. Subsection (1) of section 626.989, Florida
38 Statutes, is amended to read:

39 626.989 Investigation by department or Division of
40 Insurance Fraud; compliance; immunity; confidential information;
41 reports to division; division investigator's power of arrest.—



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42 (1) For the purposes of this section:⁷

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

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

57 2. Knowingly submits:

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

66 b. A claim for payment or other benefit pursuant to an
67 insurance policy under the Florida Motor Vehicle No-Fault Law or
68 the Florida Motor Vehicle No-Fault Emergency Care Coverage Law
69 if the person knows that the payee knowingly submitted a false,
70 misleading, or fraudulent application or other document when



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71 applying for licensure as a health care clinic, seeking an
72 exemption from licensure as a health care clinic, or
73 demonstrating compliance with part X of chapter 400. For the
74 purposes of this section,

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

78 Section 5. Section 626.9895, Florida Statutes, is created
79 to read:

80 626.9895 Motor vehicle insurance fraud direct-support
81 organization.-

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

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

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

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

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

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

98 (b) Be organized and operated to conduct programs and
99 activities; raise funds; request and receive grants, gifts, and



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100 bequests of money; acquire, receive, hold, invest, and
101 administer, in its own name, securities, funds, objects of
102 value, or other property, real or personal; and make grants and
103 expenditures to or for the direct or indirect benefit of the
104 division, state attorneys' offices, the statewide prosecutor,
105 the Agency for Health Care Administration, and the Department of
106 Health to the extent that such grants and expenditures are used
107 exclusively to advance the prosecution, investigation, or
108 prevention of motor vehicle insurance fraud. Grants and
109 expenditures may include the cost of salaries or benefits of
110 motor vehicle insurance fraud investigators, prosecutors, or
111 support personnel if such grants and expenditures do not
112 interfere with prosecutorial independence or otherwise create
113 conflicts of interest which threaten the success of
114 prosecutions.

115 (c) Be determined by the division to operate in a manner
116 that promotes the goals of laws relating to motor vehicle
117 insurance fraud, that is in the best interest of the state, and
118 that is in accordance with the adopted goals and mission of the
119 division.

120 (d) Use all of its grants and expenditures solely for the
121 purpose of preventing and decreasing motor vehicle insurance
122 fraud, and not for the purpose of lobbying as defined in s.
123 11.045.

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

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

128 (a) Approval of the articles of incorporation and bylaws of



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129 the organization by the division.

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

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

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

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

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

152 (g) The fiscal year of the organization, which begins July
153 1 of each year and ends June 30 of the following year.

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



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158 publications.

159 (4) BOARD OF DIRECTORS.—

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

162 1. The Chief Financial Officer, or designee, who shall
163 serve as chair.

164 2. Two state attorneys, one of whom shall be appointed by
165 the Chief Financial Officer and one of whom shall be appointed
166 by the Attorney General.

167 3. Two representatives of motor vehicle insurers appointed
168 by the Chief Financial Officer.

169 4. Two representatives of local law enforcement agencies,
170 one of whom shall be appointed by the Chief Financial Officer
171 and one of whom shall be appointed by the Attorney General.

172 5. Two representatives of the types of health care
173 providers who regularly make claims for benefits under the
174 Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle
175 No-Fault Emergency Care Coverage Law, one of whom shall be
176 appointed by the President of the Senate and one of whom shall
177 be appointed by the Speaker of the House of Representatives. The
178 appointees may not represent the same type of health care
179 provider.

180 6. A private attorney who has experience in representing
181 claimants in actions for benefits under the Florida Motor
182 Vehicle No-Fault Law, who shall be appointed by the President of
183 the Senate.

184 7. A private attorney who has experience in representing
185 insurers in actions for benefits under the Florida Motor Vehicle
186 No-Fault Law, who shall be appointed by the Speaker of the House



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187 of Representatives.

188 (b) The officer who appointed a member of the board may
189 remove that member for cause. The term of office of an appointed
190 member expires at the same time as the term of the officer who
191 appointed him or her or at such earlier time as the person
192 ceases to be qualified.

193 (5) USE OF PROPERTY.—The department may authorize, without
194 charge, appropriate use of fixed property and facilities of the
195 division by the organization, subject to this subsection.

196 (a) The department may prescribe any condition with which
197 the organization must comply in order to use the division's
198 property or facilities.

199 (b) The department may not authorize the use of the
200 division's property or facilities if the organization does not
201 provide equal membership and employment opportunities to all
202 persons regardless of race, religion, sex, age, or national
203 origin.

204 (c) The department shall adopt rules prescribing the
205 procedures by which the organization is governed and any
206 conditions with which the organization must comply to use the
207 division's property or facilities.

208 (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an
209 insurer to the organization shall be allowed as an appropriate
210 business expense of the insurer for all regulatory purposes.

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

215 (8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by



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216 the division from the organization shall be deposited into the
217 Insurance Regulatory Trust Fund.

218 Section 6. Subsection (12) of section 627.0651, Florida
219 Statutes, is amended to read:

220 627.0651 Making and use of rates for motor vehicle
221 insurance.—

222 (12) (a) Any portion of a judgment entered as a result of a
223 statutory or common-law bad faith action and any portion of a
224 judgment entered which awards punitive damages against an
225 insurer may ~~shall~~ not be included in the insurer's rate base,
226 and ~~shall not be~~ used to justify a rate or rate change. Any
227 portion of a settlement entered as a result of a statutory or
228 common-law bad faith action identified as such and any portion
229 of a settlement wherein an insurer agrees to pay specific
230 punitive damages may ~~shall~~ not be used to justify a rate or rate
231 change. The portion of the taxable costs and attorney ~~attorney's~~
232 fees which is identified as being related to the bad faith and
233 punitive damages in these judgments and settlements may ~~shall~~
234 not be included in the insurer's rate base and used ~~shall not be~~
235 ~~utilized~~ to justify a rate or rate change.

236 (b) Any portion of a judgment or settlement for taxable
237 costs and attorney fees in favor of a prevailing plaintiff
238 against an insurer in a claim for benefits under the Florida
239 Motor Vehicle No-Fault Law or the Florida Motor Vehicle No-Fault
240 Emergency Care Coverage Law may not be included in the insurer's
241 rate base and used to justify a rate or rate change.

242 Section 6. Subsection (6) is added to section 627.733,
243 Florida Statutes, to read:

244 627.733 Required security.—



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245 (6) The owner or registrant of a motor vehicle otherwise
246 subject to this section is not required to maintain the security
247 described herein if the owner or registrant maintains the
248 security required under s. 627.7483.

249 Section 7. Subsections (1), (4), (5), (8), (9), (10), (11),
250 and (16) of section 627.736, Florida Statutes, are amended to
251 read:

252 627.736 Required personal injury protection benefits;
253 exclusions; priority; claims.—

254 (1) REQUIRED BENEFITS.—An Every insurance policy providing
255 personal injury protection must complying with the security
256 requirements of s. 627.733 shall provide personal injury
257 protection benefits to the named insured, relatives residing in
258 the same household, persons operating the insured motor vehicle,
259 passengers in the such motor vehicle, and other persons struck
260 by the such motor vehicle and suffering bodily injury while not
261 an occupant of a self-propelled vehicle, subject to ~~the~~
262 ~~provisions of~~ subsection (2) and paragraph (4)(e), to a limit of
263 \$10,000 for loss sustained by ~~any~~ such person as a result of
264 bodily injury, sickness, disease, or death arising out of the
265 ownership, maintenance, or use of a motor vehicle as follows:

266 (a) *Medical benefits.*—Eighty percent of all reasonable
267 expenses for medically necessary medical, surgical, X-ray,
268 dental, and rehabilitative services, including prosthetic
269 devices, and medically necessary ambulance, hospital, and
270 nursing services. Medical benefits do not include massage as
271 defined in s. 480.033 or acupuncture as defined in s. 457.102.
272 ~~However,~~ The medical benefits shall provide reimbursement only
273 for ~~such~~ services and care that are lawfully provided,



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274 supervised, ordered, or prescribed by a physician licensed under
275 chapter 458 or chapter 459, a dentist licensed under chapter
276 466, or a chiropractic physician licensed under chapter 460 or
277 that are provided by any of the following ~~persons or entities~~:

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

280 2. A person or entity licensed under part III of chapter
281 401 which ~~ss. 401.2101-401.45~~ that provides emergency
282 transportation and treatment.

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

289 4. An entity wholly owned, directly or indirectly, by a
290 hospital or hospitals.

291 5. A health care clinic licensed under part X of chapter
292 400 which ~~ss. 400.990-400.995~~ that is:

293 a. A health care clinic accredited by the Joint Commission
294 on Accreditation of Healthcare Organizations, the American
295 Osteopathic Association, the Commission on Accreditation of
296 Rehabilitation Facilities, or the Accreditation Association for
297 Ambulatory Health Care, Inc.; or

298 b. A health care clinic that:

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

301 (II) Has been continuously licensed for more than 3 years
302 or is a publicly traded corporation that issues securities



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303 traded on an exchange registered with the United States
304 Securities and Exchange Commission as a national securities
305 exchange; and

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

308 (A) General medicine.

309 (B) Radiography.

310 (C) Orthopedic medicine.

311 (D) Physical medicine.

312 (E) Physical therapy.

313 (F) Physical rehabilitation.

314 (G) Prescribing or dispensing outpatient prescription
315 medication.

316 (H) Laboratory services.

317

318 The Financial Services Commission shall adopt by rule the form
319 that must be used by an insurer and a health care provider
320 specified in subparagraph 3., subparagraph 4., or subparagraph
321 5. to document that the health care provider meets the criteria
322 of this paragraph, which rule must include a requirement for a
323 sworn statement or affidavit.

324 (b) *Disability benefits.*—Sixty percent of any loss of gross
325 income and loss of earning capacity per individual from
326 inability to work proximately caused by the injury sustained by
327 the injured person, plus all expenses reasonably incurred in
328 obtaining from others ordinary and necessary services in lieu of
329 those that, but for the injury, the injured person would have
330 performed without income for the benefit of his or her
331 household. All disability benefits payable under this provision



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332 ~~must shall~~ be paid at least ~~not less than~~ every 2 weeks.

333 (c) *Death benefits.*—Death benefits equal to the lesser of
334 \$5,000 or the remainder of unused personal injury protection
335 benefits per individual. The insurer shall give priority to the
336 payment of death benefits over the payment of other benefits of
337 the deceased and, upon learning of the death of the individual,
338 shall stop paying the other benefits until the death benefits
339 are paid. The insurer may pay death ~~such~~ benefits to the
340 executor or administrator of the deceased, to any of the
341 deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection~~
342 ~~by marriage,~~ or to any person appearing to the insurer to be
343 equitably entitled to such benefits ~~thereto.~~

344
345 ~~Only insurers writing motor vehicle liability insurance in this~~
346 ~~state may provide the required benefits of this section, and no~~
347 ~~such insurer shall require the purchase of any other motor~~
348 ~~vehicle coverage other than the purchase of property damage~~
349 ~~liability coverage as required by s. 627.7275 as a condition for~~
350 ~~providing such required benefits. Insurers may not require that~~
351 ~~property damage liability insurance in an amount greater than~~
352 ~~\$10,000 be purchased in conjunction with personal injury~~
353 ~~protection. Such insurers shall make benefits and required~~
354 ~~property damage liability insurance coverage available through~~
355 ~~normal marketing channels. Any insurer writing motor vehicle~~
356 ~~liability insurance in this state who fails to comply with such~~
357 ~~availability requirement as a general business practice shall be~~
358 ~~deemed to have violated part IX of chapter 626, and such~~
359 ~~violation shall constitute an unfair method of competition or an~~
360 ~~unfair or deceptive act or practice involving the business of~~



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361 ~~insurance; and any such insurer committing such violation shall~~
362 ~~be subject to the penalties afforded in such part, as well as~~
363 ~~those which may be afforded elsewhere in the insurance code.~~

364 (4) PAYMENT OF BENEFITS; WHEN DUE. ~~Except for emergency~~
365 care coverage under ss. 627.748-627.7491, personal injury
366 protection benefits due from an insurer under ss. 627.730-
367 627.7405 are shall be primary, except that benefits received
368 under any workers' compensation law must shall be credited
369 against the benefits provided by subsection (1) and are shall be
370 due and payable as loss accrues, upon receipt of reasonable
371 proof of such loss and the amount of expenses and loss incurred
372 which are covered by the policy issued under ss. 627.730-
373 627.7405. If when the Agency for Health Care Administration
374 provides, pays, or becomes liable for medical assistance under
375 the Medicaid program related to injury, sickness, disease, or
376 death arising out of the ownership, maintenance, or use of a
377 motor vehicle, the benefits under ss. 627.730-627.7405 are shall
378 be subject to the provisions of the Medicaid program. However,
379 within 30 days after receiving notice that the Medicaid program
380 paid such benefits, the insurer shall repay the full amount of
381 the benefits to the Medicaid program.

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

386 (b) ~~Personal injury protection insurance~~ Benefits paid
387 pursuant to this section are shall be overdue if not paid within
388 30 days after the insurer is furnished written notice of the
389 fact of a covered loss and of the amount of same. However:



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390 1. If ~~such~~ written notice of the entire claim is not
391 furnished to the insurer ~~as to the entire claim~~, any partial
392 amount supported by written notice is overdue if not paid within
393 30 days after ~~such~~ written notice is furnished to the insurer.
394 Any part or all of the remainder of the claim that is
395 subsequently supported by written notice is overdue if not paid
396 within 30 days after ~~such~~ written notice is furnished to the
397 insurer.

398 2. If ~~When~~ an insurer pays only a portion of a claim or
399 rejects a claim, the insurer shall provide at the time of the
400 partial payment or rejection an itemized specification of each
401 item that the insurer had reduced, omitted, or declined to pay
402 and any information that the insurer desires the claimant to
403 consider related to the medical necessity of the denied
404 treatment or to explain the reasonableness of the reduced charge
405 ~~if, provided that this~~ does shall not limit the introduction of
406 evidence at trial. ~~and~~ The insurer must also shall include the
407 name and address of the person to whom the claimant should
408 respond and a claim number to be referenced in future
409 correspondence.

410 3. If an insurer pays only a portion of a claim or rejects
411 a claim due to an alleged error in the claim, the insurer shall
412 provide at the time of the partial payment or rejection an
413 itemized specification or explanation of benefits of the
414 specified error. Upon receiving the specification or
415 explanation, the person making the claim has, at the person's
416 option and without waiving any other legal remedy for payment,
417 15 days to submit a revised claim. The revised claim shall be
418 considered a timely submission of written notice of a claim.



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

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

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

437 (c) Upon receiving notice of an accident that is
438 potentially covered by personal injury protection benefits, the
439 insurer must reserve \$5,000 of coverage ~~of personal injury~~
440 ~~protection benefits~~ for payment to physicians licensed under
441 chapter 458 or chapter 459 or dentists licensed under chapter
442 466 who provide emergency services and care, as defined in s.
443 395.002(9), or who provide hospital inpatient care.

444
445 The amount required to be held in reserve may be used only to
446 pay claims from such physicians or dentists until 30 days after
447 the date the insurer receives notice of the accident. After the



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448 30-day period, any amount of the reserve for which the insurer
449 has not received notice of such claims ~~a claim from a physician~~
450 ~~or dentist who provided emergency services and care or who~~
451 ~~provided hospital inpatient care~~ may then be used by the insurer
452 to pay other claims. The time periods specified in paragraph (b)
453 for ~~required~~ payment of ~~personal injury protection~~ benefits are
454 ~~shall be~~ tolled for the period of time that an insurer is
455 ~~required by this paragraph~~ to hold payment of a claim that is
456 not from a physician or dentist ~~who provided emergency services~~
457 ~~and care or who provided hospital inpatient care~~ to the extent
458 that the amount ~~personal injury protection~~ benefits not held in
459 reserve is ~~are~~ insufficient to pay the claim. This paragraph
460 does not require an insurer to establish a claim reserve for
461 insurance accounting purposes.

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

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

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

475 2. Accidental bodily injury sustained outside this state,
476 but within the United States of America or its territories or



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477 possessions or Canada, by the owner while occupying the owner's
478 motor vehicle.

479 3. Accidental bodily injury sustained by a relative of the
480 owner residing in the same household, under the circumstances
481 described in subparagraph 1. or subparagraph 2., if provided the
482 relative at the time of the accident is domiciled in the owner's
483 household and is not ~~himself or herself~~ the owner of a motor
484 vehicle with respect to which security is required under ss.
485 627.730-627.7405.

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

492 a. The owner of a motor vehicle for ~~with respect to~~ which
493 personal injury protection benefits have been obtained pursuant
494 to security is required under ss. 627.730-627.7405; or

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

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

504 (g) It is a violation of the insurance code for an insurer
505 to fail to timely provide benefits as required by this section



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506 with such frequency as to constitute a general business
507 practice.

508 (h) Benefits are ~~shall~~ not be due or payable to or on the
509 behalf of an insured person if that person has committed, by a
510 material act or omission, ~~any~~ insurance fraud relating to
511 personal injury protection coverage under his or her policy, if
512 the fraud is admitted to in a sworn statement by the insured or
513 ~~if it is~~ established in a court of competent jurisdiction. Any
514 insurance fraud voids ~~shall void~~ all coverage arising from the
515 claim related to such fraud under the personal injury protection
516 coverage of the insured person who committed the fraud,
517 irrespective of whether a portion of the insured person's claim
518 may be legitimate, and any benefits paid before ~~prior to~~ the
519 discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~
520 recoverable by the insurer in its entirety from the person who
521 committed insurance fraud ~~in their entirety~~. The prevailing
522 party is entitled to its costs and attorney ~~attorney's~~ fees in
523 any action in which it prevails in an insurer's action to
524 enforce its right of recovery under this paragraph.

525 (i) An insurer shall create and maintain for each insured a
526 log of personal injury protection benefits paid by the insurer
527 on behalf of the insured. The insurer shall provide to the
528 insured, or an assignee of the insured, a copy of the log within
529 30 days after receiving a request for the log from the insured
530 or the assignee.

531 (j) In a dispute between the insured and the insurer, or
532 between an assignee of the insured's rights and the insurer, the
533 insurer must notify the insured or the assignee that the policy
534 limits under this section have been reached within 15 days after



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535 the limits have been reached.

536 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

537 (a)~~1.~~ A Any physician, hospital, clinic, or other person or
538 institution lawfully rendering treatment to an injured person
539 for a bodily injury covered by personal injury protection
540 insurance may charge the insurer and injured party only a
541 reasonable amount pursuant to this section for the services and
542 supplies rendered, and the insurer providing such coverage may
543 pay for such charges directly to such person or institution
544 lawfully rendering such treatment~~;~~ if the insured receiving such
545 treatment or his or her guardian has countersigned the properly
546 completed invoice, bill, or claim form approved by the office
547 upon which such charges are to be paid for as having actually
548 been rendered, to the best knowledge of the insured or his or
549 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
550 exceed ~~be in excess of~~ the amount the person or institution
551 customarily charges for like services or supplies. In
552 determining ~~With respect to a determination of~~ whether a charge
553 for a particular service, treatment, or supply ~~otherwise~~ is
554 reasonable, consideration may be given to evidence of usual and
555 customary charges and payments accepted by the provider involved
556 in the dispute, ~~and~~ reimbursement levels in the community and
557 various federal and state medical fee schedules applicable to
558 motor vehicle ~~automobile~~ and other insurance coverages, and
559 other information relevant to the reasonableness of the
560 reimbursement for the service, treatment, or supply.

561 1.2. The insurer may limit reimbursement to 80 percent of
562 the following schedule of maximum charges:

563 a. For emergency transport and treatment by providers



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564 licensed under chapter 401, 200 percent of Medicare.

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

568 c. For emergency services and care as defined by s.
569 395.002~~(9)~~ provided in a facility licensed under chapter 395
570 rendered by a physician or dentist, and related hospital
571 inpatient services rendered by a physician or dentist, the usual
572 and customary charges in the community.

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

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

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

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

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

589 (III) The Durable Medical Equipment Prosthetics/Orthotics
590 and Supplies fee schedule of Medicare Part B, in the case of
591 durable medical equipment.
592



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

602 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable fee
603 schedule or payment limitation under Medicare is the fee
604 schedule or payment limitation in effect on January 1 of the
605 year in which ~~at the time~~ the services, supplies, or care is ~~was~~
606 rendered and for the area in which such services, supplies, or
607 care is ~~were~~ rendered, and the applicable fee schedule or
608 payment limitation applies throughout the remainder of that
609 year, notwithstanding any subsequent change made to the fee
610 schedule or payment limitation, except that it may not be less
611 than the allowable amount under the applicable participating
612 ~~physicians~~ schedule of Medicare Part B for 2007 for medical
613 services, supplies, and care subject to Medicare Part B.

614 ~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to apply
615 any limitation on the number of treatments or other utilization
616 limits that apply under Medicare or workers' compensation. An
617 insurer that applies the allowable payment limitations of
618 subparagraph 1. 2. must reimburse a provider who lawfully
619 provided care or treatment under the scope of his or her
620 license, regardless of whether such provider is ~~would be~~
621 entitled to reimbursement under Medicare due to restrictions or



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622 limitations on the types or discipline of health care providers
623 who may be reimbursed for particular procedures or procedure
624 codes. However, subparagraph 1. does not prohibit an insurer
625 from using the Medicare coding policies and payment
626 methodologies of the federal Centers for Medicare and Medicaid
627 Services, including applicable modifiers, to determine the
628 appropriate amount of reimbursement for medical services,
629 supplies, or care if the coding policy or payment methodology
630 does not constitute a utilization limit.

631 ~~4.5.~~ If an insurer limits payment as authorized by
632 subparagraph 1. 2., the person providing such services,
633 supplies, or care may not bill or attempt to collect from the
634 insured any amount in excess of such limits, except for amounts
635 that are not covered by the insured's personal injury protection
636 coverage due to the coinsurance amount or maximum policy limits.

637 5. Effective January 1, 2013, an insurer may limit payment
638 as authorized by this paragraph only if the insurance policy
639 includes a notice at the time of issuance or renewal that the
640 insurer may limit payment pursuant to the schedule of charges
641 specified in this paragraph. A policy form approved by the
642 office satisfies this requirement. If a provider submits a
643 charge for an amount less than the amount allowed under
644 subparagraph 1., the insurer may pay the amount of the charge
645 submitted.

646 (b)1. An insurer or insured is not required to pay a claim
647 or charges:

648 a. Made by a broker or by a person making a claim on behalf
649 of a broker;

650 b. For any service or treatment that was not lawful at the



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651 time rendered;

652 c. To any person who knowingly submits a false or
653 misleading statement relating to the claim or charges;

654 d. With respect to a bill or statement that does not
655 substantially meet the applicable requirements of paragraph (d);

656 e. For any treatment or service that is upcoded, or that is
657 unbundled when such treatment or services should be bundled, in
658 accordance with paragraph (d). To facilitate prompt payment of
659 lawful services, an insurer may change codes that it determines
660 ~~to~~ have been improperly or incorrectly upcoded or unbundled, and
661 may make payment based on the changed codes, without affecting
662 the right of the provider to dispute the change by the insurer,
663 if, provided that before doing so, the insurer contacts must
664 ~~contact~~ the health care provider and discusses discuss the
665 reasons for the insurer's change and the health care provider's
666 reason for the coding, or makes make a reasonable good faith
667 effort to do so, as documented in the insurer's file; and

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

674 2. The Department of Health, in consultation with the
675 appropriate professional licensing boards, shall adopt, by rule,
676 a list of diagnostic tests deemed not to be medically necessary
677 for use in the treatment of persons sustaining bodily injury
678 covered by personal injury protection benefits under this
679 section. The ~~initial list shall be adopted by January 1, 2004,~~



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680 ~~and~~ shall be revised from time to time as determined by the
681 Department of Health, in consultation with the respective
682 professional licensing boards. Inclusion of a test on the list
683 ~~of invalid diagnostic tests~~ shall be based on lack of
684 demonstrated medical value and a level of general acceptance by
685 the relevant provider community and may ~~shall~~ not be dependent
686 for results entirely upon subjective patient response.
687 Notwithstanding its inclusion on a fee schedule in this
688 subsection, an insurer or insured is not required to pay any
689 charges or reimburse claims for an ~~any~~ invalid diagnostic test
690 as determined by the Department of Health.

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



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709 the injured person or insured to pay for such charges is
710 unenforceable.

711 ~~1.2.~~ If, ~~however,~~ the insured fails to furnish the provider
712 with the correct name and address of the insured's personal
713 injury protection insurer, the provider has 35 days from the
714 date the provider obtains the correct information to furnish the
715 insurer with a statement of the charges. The insurer is not
716 required to pay for such charges unless the provider includes
717 with the statement documentary evidence that was provided by the
718 insured during the 35-day period demonstrating that the provider
719 reasonably relied on erroneous information from the insured and
720 either:

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

725 ~~2.3.~~ For emergency services and care ~~as defined in s.~~
726 ~~395.002~~ rendered in a hospital emergency department or for
727 transport and treatment rendered by an ambulance provider
728 licensed pursuant to part III of chapter 401, the provider is
729 not required to furnish the statement of charges within the time
730 periods established by this paragraph, ~~+~~ and the insurer is ~~shall~~
731 not ~~be~~ considered to have been furnished with notice of the
732 amount of covered loss for purposes of paragraph (4) (b) until it
733 receives a statement complying with paragraph (d), or copy
734 thereof, which specifically identifies the place of service to
735 be a hospital emergency department or an ambulance in accordance
736 with billing standards recognized by the federal Centers for
737 Medicare and Medicaid Services ~~Health Care Finance~~



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738 ~~Administration.~~

739 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
740 must include the following statement in at least 12-point type
741 ~~in type no smaller than 12 points:~~

742

743 BILLING REQUIREMENTS.—Florida law provides ~~Statutes~~
744 ~~provide~~ that with respect to any treatment or
745 services, other than certain hospital and emergency
746 services, the statement of charges furnished to the
747 insurer by the provider may not include, and the
748 insurer and the injured party are not required to pay,
749 charges for treatment or services rendered more than
750 35 days before the postmark date of the statement,
751 except for past due amounts previously billed on a
752 timely basis, and except that, if the provider submits
753 to the insurer a notice of initiation of treatment
754 within 21 days after its first examination or
755 treatment of the claimant, the statement may include
756 charges for treatment or services rendered up to, but
757 not more than, 75 days before the postmark date of the
758 statement.

759

760 (d) All statements and bills for medical services rendered
761 by a ~~any~~ physician, hospital, clinic, or other person or
762 institution shall be submitted to the insurer on a properly
763 completed Centers for Medicare and Medicaid Services (CMS) 1500
764 form, UB 92 forms, or any other standard form approved by the
765 office or adopted by the commission for purposes of this
766 paragraph. All billings for such services rendered by providers



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767 must ~~shall~~, to the extent applicable, follow the Physicians'
768 Current Procedural Terminology (CPT) or Healthcare Correct
769 Procedural Coding System (HCPCS), or ICD-9 in effect for the
770 year in which services are rendered and comply with the ~~Centers~~
771 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions,
772 ~~and~~ the American Medical Association ~~Current Procedural~~
773 ~~Terminology (CPT)~~ Editorial Panel, and the Healthcare Correct
774 ~~Procedural Coding System (HCPCS)~~. All providers, other than
775 hospitals, must ~~shall~~ include on the applicable claim form the
776 professional license number of the provider in the line or space
777 provided for "Signature of Physician or Supplier, Including
778 Degrees or Credentials." In determining compliance with
779 applicable CPT and HCPCS coding, guidance shall be provided by
780 the Physicians' Current Procedural Terminology (CPT) or the
781 Healthcare Correct Procedural Coding System (HCPCS) in effect
782 for the year in which services were rendered, the Office of the
783 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
784 other authoritative treatises designated by rule by the Agency
785 for Health Care Administration. A ~~No~~ statement of medical
786 services may not include charges for medical services of a
787 person or entity that performed such services without possessing
788 the valid licenses required to perform such services. For
789 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
790 considered to have been furnished with notice of the amount of
791 covered loss or medical bills due unless the statements or bills
792 comply with this paragraph, ~~and unless the statements or bills~~
793 are properly completed in their entirety as to all material
794 provisions, with all relevant information being provided
795 therein.



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

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

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

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

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

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

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

824 3. Countersignature by the insured, or his or her guardian,



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825 is not required for the reading of diagnostic tests or other
826 services that are of such a nature that they are not required to
827 be performed in the presence of the insured.

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

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

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

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

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

852 9. The requirements of this paragraph apply only with
853 respect to the initial treatment or service of the insured by a



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854 provider. For subsequent treatments or service, the provider
855 must maintain a patient log signed by the patient, in
856 chronological order by date of service, which ~~that~~ is consistent
857 with the services being rendered to the patient as claimed. The
858 requirement to maintain ~~requirements of this subparagraph for~~
859 ~~maintaining~~ a patient log signed by the patient may be met by a
860 hospital that maintains medical records as required by s.
861 395.3025 and applicable rules and makes such records available
862 to the insurer upon request.

863 (f) Upon written notification by any person, an insurer
864 shall investigate any claim of improper billing by a physician
865 or other medical provider. The insurer shall determine if the
866 insured was properly billed for only those services and
867 treatments that the insured actually received. If the insurer
868 determines that the insured has been improperly billed, the
869 insurer shall notify the insured, the person making the written
870 notification, and the provider of its findings and ~~shall~~ reduce
871 the amount of payment to the provider by the amount determined
872 to be improperly billed. If a reduction is made due to a such
873 written notification by any person, the insurer shall pay to the
874 person 20 percent of the amount of the reduction, up to \$500. If
875 the provider is arrested due to the improper billing, ~~then~~ the
876 insurer shall pay to the person 40 percent of the amount of the
877 reduction, up to \$500.

878 (g) An insurer may not systematically downcode with the
879 intent to deny reimbursement otherwise due. Such action
880 constitutes a material misrepresentation under s.
881 626.9541(1)(i)2.

882 (h) As provided in s. 400.9905, an entity excluded from the



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883 definition of a clinic shall be deemed a clinic and must be
884 licensed under part X of chapter 400 in order to receive
885 reimbursement under ss. 627.730-627.7405. However, this
886 licensing requirement does not apply to:

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

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

893 3. An entity wholly owned by a chiropractic physician
894 licensed under chapter 460, or by the chiropractic physician and
895 the spouse, parent, child, or sibling of the chiropractic
896 physician if such entity has filed for a licensing exemption
897 with the Agency for Health Care Administration;

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

900 5. An entity wholly owned, directly or indirectly, by a
901 hospital or hospitals licensed under chapter 395.

902 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY
903 ATTORNEY'S FEES.—With respect to any dispute under the
904 provisions of ss. 627.730-627.7405 between the insured and the
905 insurer, or between an assignee of an insured's rights and the
906 insurer, the provisions of ss. ~~s.~~ 627.428 and 768.79 shall
907 apply, except as provided in subsections (10) and (15).

908 (9) PREFERRED PROVIDERS.—An insurer may negotiate and
909 contract enter into contracts with preferred licensed health
910 care providers for the benefits described in this section,
911 including referred to in this section as "preferred providers,"



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912 ~~which shall include~~ health care providers licensed under chapter
913 ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter
914 ~~and~~ 463. The insurer may provide an option to an insured to use
915 a preferred provider at the time of purchasing ~~purchase~~ of the
916 policy ~~for personal injury protection benefits~~, if the
917 requirements of this subsection are met. If the insured elects
918 to use a provider who is not a preferred provider, whether the
919 insured purchased a preferred provider policy or a nonpreferred
920 provider policy, the medical benefits provided by the insurer
921 shall be as required by this section. If the insured elects to
922 use a provider who is a preferred provider, the insurer may pay
923 medical benefits in excess of the benefits required by this
924 section and may waive or lower the amount of any deductible that
925 applies to such medical benefits. If the insurer offers a
926 preferred provider policy to a policyholder or applicant, it
927 must also offer a nonpreferred provider policy. The insurer
928 shall provide each insured ~~policyholder~~ with a current roster of
929 preferred providers in the county in which the insured resides
930 at the time of purchase of such policy, and shall make such list
931 available for public inspection during regular business hours at
932 the insurer's principal office ~~of the insurer~~ within the state.

933 (10) DEMAND LETTER.—

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

940 (b) The notice must ~~required shall~~ state that it is a



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941 "demand letter under s. 627.736(10)" and shall state with
942 specificity:

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

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

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

962 (c) Each notice required by this subsection must be
963 delivered to the insurer by United States certified or
964 registered mail, return receipt requested. Such postal costs
965 shall be reimbursed by the insurer if so requested by the
966 claimant in the notice, when the insurer pays the claim. Such
967 notice must be sent to the person and address specified by the
968 insurer for the purposes of receiving notices under this
969 subsection. Each licensed insurer, whether domestic, foreign, or



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970 alien, shall file with the office designation of the name and
971 address of the person to whom notices must ~~pursuant to this~~
972 ~~subsection shall~~ be sent which the office shall make available
973 on its Internet website. The name and address on file with the
974 office pursuant to s. 624.422 are ~~shall be~~ deemed the authorized
975 representative to accept notice pursuant to this subsection if
976 ~~in the event~~ no other designation has been made.

977 (d) If, within 30 days after receipt of notice by the
978 insurer, the overdue claim specified in the notice is paid by
979 the insurer together with applicable interest and a penalty of
980 10 percent of the overdue amount paid by the insurer, subject to
981 a maximum penalty of \$250, no action may be brought against the
982 insurer. If the demand involves an insurer's withdrawal of
983 payment under paragraph (7) (a) for future treatment not yet
984 rendered, no action may be brought against the insurer if,
985 within 30 days after its receipt of the notice, the insurer
986 mails to the person filing the notice a written statement of the
987 insurer's agreement to pay for such treatment in accordance with
988 the notice and to pay a penalty of 10 percent, subject to a
989 maximum penalty of \$250, when it pays for such future treatment
990 in accordance with the requirements of this section. To the
991 extent the insurer determines not to pay any amount demanded,
992 the penalty is ~~shall~~ not be payable in any subsequent action.
993 For purposes of this subsection, payment or the insurer's
994 agreement shall be treated as being made on the date a draft or
995 other valid instrument that is equivalent to payment, or the
996 insurer's written statement of agreement, is placed in the
997 United States mail in a properly addressed, postpaid envelope,
998 or if not so posted, on the date of delivery. The insurer is not



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999 obligated to pay any attorney ~~attorney's~~ fees if the insurer
1000 pays the claim or mails its agreement to pay for future
1001 treatment within the time prescribed by this subsection.

1002 (e) The applicable statute of limitation for an action
1003 under this section shall be tolled for ~~a period of~~ 30 business
1004 days by the mailing of the notice required by this subsection.

1005 ~~(f) Any insurer making a general business practice of not~~
1006 ~~paying valid claims until receipt of the notice required by this~~
1007 ~~subsection is engaging in an unfair trade practice under the~~
1008 ~~insurance code.~~

1009 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
1010 PRACTICE.—

1011 (a) ~~If An insurer fails to pay valid claims for personal~~
1012 ~~injury protection with such frequency so as to indicate a~~
1013 ~~general business practice, the insurer is engaging in a~~
1014 ~~prohibited unfair or deceptive practice that is~~ subject to the
1015 penalties provided in s. 626.9521 and the office has the powers
1016 and duties specified in ss. 626.9561-626.9601 if the insurer,
1017 with such frequency so as to indicate a general business
1018 practice: with respect thereto

1019 1. Fails to pay valid claims for personal injury
1020 protection; or

1021 2. Fails to pay valid claims until receipt of the notice
1022 required by subsection (10).

1023 (b) Notwithstanding s. 501.212, the Department of Legal
1024 Affairs may investigate and initiate actions for a violation of
1025 this subsection, including, but not limited to, the powers and
1026 duties specified in part II of chapter 501.

1027 (16) SECURE ELECTRONIC DATA TRANSFER.—~~If all parties~~



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1028 ~~mutually and expressly agree,~~ A notice, documentation,
1029 transmission, or communication of any kind required or
1030 authorized under ss. 627.730-627.7405 may be transmitted
1031 electronically if it is transmitted by secure electronic data
1032 transfer that is consistent with state and federal privacy and
1033 security laws.

1034 Section 8. Section 627.748, Florida Statutes, is created to
1035 read:

1036 627.748 Short title.—Sections 627.748-627.7491 may be cited
1037 as the "Florida Motor Vehicle No-Fault Emergency Care Coverage
1038 Law."

1039 Section 9. Section 627.7481, Florida Statutes, is created
1040 to read:

1041 627.7481 Purposes.—The purpose of the Florida Motor Vehicle
1042 No-Fault Emergency Care Coverage Law is to provide for emergency
1043 services and care, services and care provided in a hospital,
1044 prescribed follow-up care, funeral costs, and disability
1045 insurance benefits without regard to fault; to require motor
1046 vehicle insurance that secures such benefits for motor vehicles
1047 required to be registered in this state; and, with respect to
1048 motor vehicle accidents, to provide a limitation on the right to
1049 claim damages for pain, suffering, mental anguish, and
1050 inconvenience.

1051 Section 10. Section 627.74811, Florida Statutes, is created
1052 to read:

1053 627.74811 Effect of law on emergency care coverage
1054 policies.—The provisions, schedules, and procedures authorized
1055 in ss. 627.748-627.7491 must be implemented by insurers offering
1056 policies pursuant to the Florida Motor Vehicle No-Fault



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1057 Emergency Care Coverage Law. The Legislature intends that these
1058 provisions, schedules, and procedures have full force and effect
1059 regardless of their express inclusion in an insurance policy
1060 form and govern over any general provisions in the insurance
1061 policy form. An insurer is not required to amend its policy form
1062 or to expressly notify providers, claimants, or insureds of the
1063 applicable fee schedules in order to implement and apply such
1064 provisions, schedules, or procedures.

1065 Section 11. Section 627.7482, Florida Statutes, is created
1066 to read:

1067 627.7482 Definitions.—As used in ss. 627.748-627.7491, the
1068 term:

1069 (1) "Broker" means any person not licensed under chapter
1070 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter
1071 460, chapter 461, or chapter 641 who charges or receives
1072 compensation for the use of medical equipment and is not the 100
1073 percent owner or the 100 percent lessee of such equipment. For
1074 purposes of this subsection, such owner or lessee may be an
1075 individual, a corporation, a partnership, or any other entity
1076 and any of its 100 percent owned affiliates and subsidiaries.

1077 (a) The term "broker" does not include:

1078 1. A hospital or physician management company whose medical
1079 equipment is ancillary to the practices managed; a debt
1080 collection agency; an entity that has contracted with the
1081 insurer to obtain a discounted rate; a management company that
1082 has contracted to provide general management services for a
1083 licensed physician or health care facility and whose
1084 compensation is not materially affected by the usage or
1085 frequency of usage of medical equipment; or an entity that is



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1086 100 percent owned by one or more hospitals or physicians.
1087 2. A person or entity that certifies, upon the request of
1088 an insurer, that:
1089 a. It is a clinic licensed under part X of chapter 400;
1090 b. It is a 100 percent owner of medical equipment; and
1091 c. The owner's only part-time lease of medical equipment
1092 for emergency care coverage patients is on a temporary basis not
1093 to exceed 30 days in a 12-month period and is necessitated by:
1094 (I) The repair or maintenance of existing 100 percent-owned
1095 medical equipment;
1096 (II) The pending arrival and installation of newly
1097 purchased medical equipment or the replacement 100-percent-owned
1098 medical equipment; or
1099 (III) A determination by the medical director or clinical
1100 director that open-style medical equipment is medically
1101 necessary for the performance of tests or procedures for
1102 patients due to the patients' physical sizes or claustrophobia.
1103 The leased medical equipment may not be used, for medical
1104 treatment or services, for a patient who is not a patient of the
1105 registered clinic for medical treatment of services.
1106
1107 However, the 30-day lease period provided in this sub-
1108 subparagraph may be extended for an additional 60 days as
1109 applicable to magnetic resonance imaging equipment if the owner
1110 certifies that the extension otherwise complies with this
1111 paragraph.
1112 (b) As used in this subsection, the term "lessee" means a
1113 long-term lessee under a capital or operating lease but does not
1114 include a part-time lessee.



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1115 (c) Any person or entity making a false certification under
1116 this subsection commits insurance fraud as defined in s.
1117 817.234.

1118 (2) "Certify" means to swear or attest to a fact being true
1119 or accurately represented in a writing.

1120 (3) "Emergency medical condition" means:

1121 (a) A medical condition manifesting itself by acute
1122 symptoms of sufficient severity, which may include severe pain,
1123 such that the absence of immediate medical attention could
1124 reasonably be expected to result in any of the following:

1125 1. Serious jeopardy to the health of a patient, including a
1126 pregnant woman or fetus.

1127 2. Serious impairment to bodily functions.

1128 3. Serious dysfunction of any bodily organ or part.

1129 (b) With respect to a pregnant woman:

1130 1. That there is inadequate time for a safe transfer to
1131 another hospital before delivery;

1132 2. That a transfer may pose a threat to the health and
1133 safety of the woman or fetus; or

1134 3. That there is evidence of the onset and persistence of
1135 uterine contractions or rupture of the membranes.

1136 (4) "Emergency services and care" means medical screening,
1137 examination and evaluation by a physician or, to the extent
1138 permitted by applicable law, by other appropriate personnel
1139 under the supervision of a physician, to determine if an
1140 emergency medical condition exists and, if it does, the care,
1141 treatment, or surgery by a physician necessary to relieve or
1142 eliminate the emergency medical condition, within the service
1143 capability of the facility.



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1144 (5) "Hospital" means a facility that, at the time services
1145 or treatment was rendered, was licensed under chapter 395.

1146 (6) "Knowingly" means having actual knowledge of
1147 information and acting in deliberate ignorance of the truth or
1148 falsity of the information or in reckless disregard of the
1149 information. Proof of specific intent to defraud is not
1150 required.

1151 (7) "Lawful" or "lawfully" means in substantial compliance
1152 with all relevant applicable criminal, civil, and administrative
1153 requirements of state and federal law related to the provision
1154 of medical services or treatment.

1155 (8) "Medically necessary" refers to a medical service or
1156 supply that a prudent physician would provide for the purpose of
1157 preventing, diagnosing, or treating an illness, injury, disease,
1158 or symptom in a manner that is:

1159 (a) In accordance with generally accepted standards of
1160 medical practice;

1161 (b) Clinically appropriate in terms of type, frequency,
1162 extent, site, and duration; and

1163 (c) Not primarily for the convenience of the patient,
1164 physician, or other health care provider.

1165 (9) "Motor vehicle" means any self-propelled vehicle that
1166 has four or more wheels and is of a type both designed and
1167 required to be licensed for use on the highways of this state
1168 and any trailer or semitrailer designed for use with such
1169 vehicle. The term includes:

1170 (a) A "private passenger motor vehicle," which is any motor
1171 vehicle that is a sedan, station wagon, or jeep-type vehicle
1172 and, if not used primarily for occupational, professional, or



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1173 business purposes, a motor vehicle of the pickup truck, panel
1174 truck, van, camper, or motor home type.

1175 (b) A "commercial motor vehicle," which is a motor vehicle
1176 that is not a private passenger motor vehicle.

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1178 The term does not include a mobile home or a motor vehicle that
1179 is used in mass transit, other than public school
1180 transportation; is designed to transport more than five
1181 passengers exclusive of the operator of the motor vehicle; and
1182 is owned by a municipality, a transit authority, or a political
1183 subdivision of the state.

1184 (10) "Named insured" means a person, usually the owner of a
1185 motor vehicle, identified in a policy by name as the insured
1186 under the policy.

1187 (11) "Owner," with respect to a motor vehicle, means a
1188 person who holds legal title to the motor vehicle or, if the
1189 motor vehicle is the subject of a security agreement or lease
1190 with an option to purchase and the debtor or lessee has the
1191 right to possession, the debtor or lessee of the motor vehicle.

1192 (12) "Physician" means an allopathic physician licensed
1193 under chapter 458 or an osteopathic physician licensed under
1194 chapter 459.

1195 (13) "Properly completed" means providing truthful,
1196 substantially complete, and substantially accurate responses as
1197 to all material elements to each applicable request for
1198 information or statement by a means that may lawfully be
1199 provided and that complies with this section, or as otherwise
1200 agreed to by the parties.

1201 (14) "Relative residing in the insured's household" means a



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1202 relative of any degree by blood, marriage, or adoption who
1203 usually makes her or his home in the same family unit regardless
1204 of whether she or he is temporarily living elsewhere.

1205 (15) "Unbundling" means separating treatment or services
1206 that would be properly billed under one billing code into two or
1207 more billing codes, resulting in a payment amount greater than
1208 would be paid using one billing code.

1209 (16) "Upcoding" means using a billing code to describe
1210 treatment or services in a manner that would result in a payment
1211 amount greater than would be paid using a billing code that
1212 accurately describes such treatment or services. The term does
1213 not include an otherwise lawful bill by a magnetic resonance
1214 imaging facility, which globally combines both technical and
1215 professional components, if the amount of the global bill is not
1216 more than the components if billed separately; however, payment
1217 of such a bill constitutes payment in full for all components of
1218 such service.

1219 Section 12. Section 627.7483, Florida Statutes, is created
1220 to read:

1221 627.7483 Required security.-

1222 (1) An owner or registrant of a motor vehicle, other than a
1223 motor vehicle used as a school bus as defined in s. 1006.25, a
1224 limousine, or a taxicab, which must be registered and licensed
1225 in this state shall continuously maintain security as described
1226 in subsection (3) throughout the licensing or registration
1227 period. An owner or registrant of a motor vehicle used as a
1228 taxicab shall maintain security as required under s. 324.032(1)
1229 and is exempt from s. 627.7486.

1230 (2) A nonresident owner or registrant of a motor vehicle,



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1231 whether operated or not operated, which has been physically
1232 present within this state for more than 90 days during the
1233 preceding 365 days must thereafter continuously maintain
1234 security as described in subsection (3) while such motor vehicle
1235 is physically present within this state.

1236 (3) Security required by this section shall be provided:

1237 (a) By an insurance policy delivered or issued for delivery
1238 in this state by an authorized or eligible motor vehicle
1239 liability insurer which provides the benefits and exemptions
1240 contained in ss. 627.748-627.7491. Any policy of insurance
1241 represented or sold as providing the security required under
1242 this section shall be deemed to provide insurance for the
1243 payment of the required benefits; or

1244 (b) By any other method authorized by s. 324.031(2), (3),
1245 or (4) and approved by the Department of Highway Safety and
1246 Motor Vehicles as affording security equivalent to that afforded
1247 by a policy of insurance or by self-insuring as authorized by s.
1248 768.28(16). The person filing such security has all of the
1249 obligations and rights of an insurer under ss. 627.748-627.7491.

1250 (4) An owner of a motor vehicle for which security is
1251 required by this section who fails to have such security in
1252 effect at the time of an accident is not immune from tort
1253 liability and is personally liable for the payment of benefits
1254 under s. 627.7485. With respect to such benefits, the owner has
1255 all of the rights and obligations of an insurer under ss.
1256 627.748-627.7491.

1257 (5) In addition to persons who are not required to provide
1258 security under this section or s. 324.022, the owner or
1259 registrant of a motor vehicle who is a member of the United



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1260 States Armed Forces and who is called to or on active duty
1261 outside the United States in an emergency situation is exempt
1262 from such requirements. The exemption applies only while the
1263 owner or registrant is on such active duty and while the motor
1264 vehicle otherwise required to be covered by the security under
1265 this section or s. 324.022 is not operated by any person. Upon
1266 receipt of a written request from the insured to whom this
1267 exemption applies, the insurer shall cancel the coverages and
1268 return any unearned premium or suspend the security required by
1269 this section and s. 324.022. Notwithstanding s. 324.0221(2), the
1270 Department of Highway Safety and Motor Vehicles may not suspend
1271 the registration or operator's license of the owner or
1272 registrant of a motor vehicle during the time she or he
1273 qualifies for this exemption. The owner or registrant of the
1274 motor vehicle qualifying for the exemption must immediately
1275 notify the department before and at the end of the expiration of
1276 the exemption.

1277 Section 13. Section 627.7484, Florida Statutes, is created
1278 to read:

1279 627.7484 Proof of security; security requirements;
1280 penalties.—

1281 (1) The provisions of chapter 324 which pertain to the
1282 method of giving and maintaining proof of financial
1283 responsibility and which govern and define a motor vehicle
1284 liability policy apply to filing and maintaining proof of
1285 security required by ss. 627.748-627.7491.

1286 (2) Any person who:

1287 (a) Gives information required in a report or otherwise as
1288 provided in ss. 627.748-627.7491, knowing or having reason to



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1289 believe that such information is false;

1290 (b) Forges or, without authority, signs any evidence of
1291 proof of security; or

1292 (c) Files, or offers for filing, any such evidence of
1293 proof, knowing or having reason to believe that it is forged or
1294 signed without authority

1295

1296 commits a misdemeanor of the first degree, punishable as
1297 provided in s. 775.082 or s. 775.083.

1298 Section 14. Section 627.7485, Florida Statutes, is created
1299 to read:

1300 627.7485 Required emergency care coverage benefits.-

1301 (1) REQUIRED BENEFITS.-An insurance policy complying with
1302 the security requirements of s. 627.7483 must provide emergency
1303 care coverage to the named insured, relatives residing in the
1304 insured's household, persons operating the insured motor
1305 vehicle, passengers in the motor vehicle, and other persons
1306 struck by such motor vehicle and suffering bodily injury while
1307 not an occupant of a self-propelled vehicle, subject to
1308 subsection (2) and paragraph (4) (b), up to a limit of \$10,000,
1309 for loss sustained by any such person as a result of bodily
1310 injury, sickness, disease, or death arising out of the
1311 ownership, maintenance, or use of the motor vehicle as follows:

1312 (a) Medical benefits.-

1313 1. Eighty percent of all reasonable expenses for:

1314 a. Emergency transport and treatment rendered by an
1315 ambulance provider licensed under part III of chapter 401 within
1316 24 hours after the motor vehicle accident.

1317 b. Emergency services and care rendered by a dentist,



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1318 provided within 7 days after the motor vehicle accident if such
1319 services and care are provided:

1320 (I) In a hospital or in a facility wholly owned by a
1321 hospital;

1322 (II) In a facility wholly owned by a physician, or by the
1323 physician and the spouse, parents, children, or siblings of such
1324 physician; or

1325 (III) In a facility wholly owned by a dentist, or by the
1326 dentist and the spouse, parents, children, or siblings of such
1327 dentist.

1328 c. Services and care rendered when an insured is admitted
1329 to a hospital within 7 days after the motor vehicle accident,
1330 for a condition related to the motor vehicle accident.

1331 d. If the insured receives emergency transport and
1332 treatment or emergency services and care pursuant to sub-sub-
1333 subparagraph a. or sub-subparagraph b., or services and care
1334 pursuant to sub-subparagraph c., prescribed follow-up services
1335 and care directly related to the medical diagnosis arising from
1336 the motor vehicle accident if:

1337 (I) The diagnosis is rendered by a physician; and

1338 (II) The prescribed follow-up services and care are
1339 rendered by a physician, a dentist licensed under chapter 466, a
1340 physician assistant licensed under chapter 458 or chapter 459,
1341 an advanced registered nurse practitioner licensed under chapter
1342 464, or a chiropractic physician licensed under chapter 460.

1343 2. Prescribed follow-up services and care must be provided
1344 in a clinic licensed under part X of chapter 400 or an entity
1345 excluded from the definition of a clinic. However, as provided
1346 in s. 400.9905, an entity excluded from the definition of a



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1347 clinic shall be deemed a clinic and must be licensed under part
1348 X of chapter 400 in order to receive reimbursement for
1349 prescribed follow-up services and care under sub-subparagraph
1350 1.d. unless the entity is:
1351 a. An entity wholly owned by a physician licensed under
1352 chapter 458 or chapter 459, or by the physician and the spouse,
1353 parent, child, or sibling of the physician;
1354 b. An entity wholly owned by a dentist licensed under
1355 chapter 466, or by the dentist and the spouse, parent, child, or
1356 sibling of the dentist;
1357 c. An entity wholly owned by a chiropractic physician
1358 licensed under chapter 460, or by the chiropractic physician and
1359 the spouse, parent, child, or sibling of the chiropractic
1360 physician if such entity has filed for a licensing exemption
1361 with the Agency for Health Care Administration;
1362 d. A hospital or ambulatory surgical center licensed under
1363 chapter 395; or
1364 e. An entity wholly owned, directly or indirectly, by a
1365 hospital or hospitals licensed under chapter 395.
1366 3. Reimbursement for services provided by a chiropractic
1367 physician is limited to the lesser of 24 treatments or to
1368 services rendered within 12 weeks after the date of the initial
1369 chiropractic treatment, whichever comes first, unless the
1370 insurer authorizes additional chiropractic services.
1371 4. Medical benefits do not include massage as defined in s.
1372 480.033 or acupuncture as defined in s. 457.102.
1373 5. For purposes of ss. 627.748-627.7491, a medical
1374 diagnosis that an emergency medical condition exists is presumed
1375 to be correct unless rebutted by clear and convincing evidence



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1376 to the contrary.

1377 (b) Disability benefits.—Sixty percent of any loss of gross
1378 income and loss of earning capacity per individual from
1379 inability to work proximately caused by the injury sustained by
1380 the injured person, plus all expenses reasonably incurred in
1381 obtaining from others ordinary and necessary services in lieu of
1382 those that, but for the injury, the injured person would have
1383 performed without income for the benefit of her or his
1384 household. All disability benefits payable under this paragraph
1385 must be paid at least every 2 weeks.

1386 (c) Death benefits.—Death benefits equal to the lesser of
1387 \$5,000 or the remainder of unused emergency care coverage
1388 insurance benefits per individual. The insurer shall give
1389 priority to the payment of death benefits over the payment of
1390 other benefits of the deceased and, upon learning of the death
1391 of the individual, shall stop paying the other benefits until
1392 the death benefits are paid. The insurer may pay death benefits
1393 to the executor or administrator of the deceased, to any of the
1394 deceased's relatives by blood, legal adoption, or marriage, or
1395 to any person who appears to the insurer to be equitably
1396 entitled to such benefits.

1397
1398 Only insurers writing motor vehicle liability insurance in this
1399 state may provide the benefits required by this section, and
1400 such insurer may not require the purchase of any other motor
1401 vehicle coverage other than the purchase of property damage
1402 liability coverage as required by s. 627.7275 as a condition for
1403 providing such benefits. Insurers may not require that property
1404 damage liability insurance in an amount greater than \$10,000 be



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1405 purchased in conjunction with emergency care coverage insurance.
1406 Such insurers shall make benefits and required property damage
1407 liability insurance coverage available through normal marketing
1408 channels. An insurer writing motor vehicle liability insurance
1409 in this state who fails to comply with such availability
1410 requirement as a general business practice violates part IX of
1411 chapter 626, and such violation constitutes an unfair method of
1412 competition or an unfair or deceptive act or practice involving
1413 the business of insurance. An insurer committing such violation
1414 is subject to the penalties provided under that part, as well as
1415 those provided elsewhere in the insurance code.

1416 (2) AUTHORIZED EXCLUSIONS.—An insurer may exclude benefits:

1417 (a) For injury sustained by the named insured and relatives
1418 residing in the insured's household while occupying another
1419 motor vehicle owned by the named insured and not insured under
1420 the policy or for injury sustained by any person operating the
1421 insured motor vehicle without the express or implied consent of
1422 the insured.

1423 (b) To any injured person if such person's conduct
1424 contributed to her or his injury under the following
1425 circumstance:

- 1426 1. Causing injury to herself or himself intentionally; or
1427 2. Being injured while committing a felony.

1428
1429 If an insured is charged with conduct as set forth in
1430 subparagraph 2., the 30-day payment provision of paragraph
1431 (4) (f) shall be held in abeyance, and the insurer shall withhold
1432 payment of any benefits pending the outcome of the case at the
1433 trial level. If the charge is nolle prossed or dismissed or the



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1434 insured is acquitted, the 30-day payment provision shall run
1435 from the date the insurer is notified of such action.

1436 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT
1437 CLAIMS.—An insurer may not have a lien on any recovery in tort
1438 by judgment, settlement, or otherwise for emergency care
1439 coverage benefits, whether suit has been filed or settlement has
1440 been reached without suit. An injured party who is entitled to
1441 bring suit under ss. 627.748-627.7491, or her or his legal
1442 representative, may not recover any damages for which benefits
1443 are paid or payable. The plaintiff may prove all of her or his
1444 special damages notwithstanding this limitation, but if special
1445 damages are introduced in evidence, the trier of facts, whether
1446 judge or jury, may not award damages for emergency care coverage
1447 benefits paid or payable. In all cases in which a jury is
1448 required to fix damages, the court shall instruct the jury that
1449 the plaintiff may not recover such special damages for emergency
1450 care coverage benefits paid or payable.

1451 (4) PAYMENT OF BENEFITS.—

1452 (a) Benefits due from an insurer under ss. 627.748-627.7491
1453 are primary, except that benefits received under any workers'
1454 compensation law must be credited against the benefits provided
1455 under subsection (1) and are due and payable as loss accrues
1456 upon receipt of reasonable proof of such loss and the amount of
1457 expenses and loss incurred that are covered by the policy issued
1458 under ss. 627.748-627.7491. If the Agency for Health Care
1459 Administration provides, pays, or becomes liable for medical
1460 assistance under the Medicaid program related to injury,
1461 sickness, disease, or death arising out of the ownership,
1462 maintenance, or use of a motor vehicle, the benefits under ss.



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1463 627.748-627.7491 are subject to the provisions of the Medicaid
1464 program. However, within 30 days after receiving notice that the
1465 Medicaid program paid such benefits, the insurer must repay the
1466 full amount of the benefits to the Medicaid program.

1467 (b) The insurer of the owner of a motor vehicle shall pay
1468 benefits for an emergency medical condition as described in
1469 paragraph (1) (a) for accidental bodily injury requiring medical
1470 treatment:

1471 1. Sustained in this state by the owner while occupying a
1472 motor vehicle, or while not an occupant of a self-propelled
1473 vehicle if the injury is caused by physical contact with a motor
1474 vehicle.

1475 2. Sustained outside this state, but within the United
1476 States or its territories or possessions or Canada, by the owner
1477 while occupying the owner's motor vehicle.

1478 3. Sustained by a relative of the owner residing in the
1479 owner's household, under the circumstances described in
1480 subparagraph 1. or subparagraph 2. if the relative at the time
1481 of the accident is domiciled in the owner's household and is not
1482 the owner of a motor vehicle with respect to which security is
1483 required under ss. 627.748-627.7491.

1484 4. Sustained in this state by any other person while
1485 occupying the owner's motor vehicle or, if a resident of this
1486 state, while not an occupant of a self-propelled vehicle, if the
1487 injury is caused by physical contact with such motor vehicle if
1488 the injured person is not:

1489 a. The owner of a motor vehicle for which security is
1490 required under ss. 627.748-627.7491; or

1491 b. Entitled to benefits from the insurer of the owner of



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1492 such motor vehicle.

1493 (c) An insurer may require written notice to be given as
1494 soon as practicable after an accident involving a motor vehicle
1495 for which the policy provides the security required by ss.
1496 627.748-627.7491.

1497 (d) Upon receiving notice of an accident that is
1498 potentially covered by benefits under this section, the insurer
1499 must reserve \$5,000 of such coverage for payment of medical
1500 benefits provided by physicians or dentists pursuant to
1501 subparagraph (1)(a). The reserved amount may be used only to pay
1502 claims for such providers until 30 days after the date the
1503 insurer receives notice of the accident. After the 30-day
1504 period, any amount of the reserve for which the insurer has not
1505 received notice of a claim for emergency care coverage benefits
1506 may be used to pay other claims. The time periods specified in
1507 paragraph (f) for the payment of benefits shall be tolled for
1508 the period of time that the insurer is required by this
1509 paragraph to hold payment of such other claims to the extent
1510 that the amount not held in reserve is insufficient to pay such
1511 other claims. This paragraph does not require an insurer to
1512 establish a claim reserve for insurance accounting purposes.

1513 (e) An insurer shall create and maintain for each insured a
1514 log of benefits paid by the insurer on behalf of the insured.
1515 The insurer shall provide to the insured, or an assignee of the
1516 insured, a copy of the log within 30 days after receiving a
1517 request for the log from the insured or the assignee.

1518 (f) Benefits paid pursuant to this section are overdue if
1519 not paid within 30 days after written notice of the fact and
1520 amount of a covered loss is furnished to the insurer.



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1521 1. If written notice of the entire claim is not furnished
1522 to the insurer, any partial amount supported by the written
1523 notice is overdue if not paid within 30 days after the written
1524 notice is furnished. Any part or all of the remainder of the
1525 claim that is subsequently supported by written notice is
1526 overdue if not paid within 30 days after subsequent written
1527 notice is furnished to the insurer.

1528 2. This paragraph does not preclude or limit the ability of
1529 the insurer to assert that the claim or a portion of the claim
1530 was unrelated, was not medically necessary, or was unreasonable,
1531 or that the amount of the charge was in excess of that permitted
1532 under, or in violation of, subsection (5). Such assertion may be
1533 made at any time, including after payment of the claim or after
1534 the 30-day period for payment set forth in this paragraph.

1535 3. If an insurer pays only a portion of a claim or rejects
1536 a claim, the insurer shall provide at the time of the partial
1537 payment or rejection an itemized specification of each item that
1538 the insurer has reduced, omitted, or declined to pay and any
1539 information that the insurer desires the claimant to consider
1540 related to the medical necessity of the denied treatment or to
1541 explain the reasonableness of the reduced charge if this
1542 information does not limit the introduction of evidence at
1543 trial. The insurer must also include the name and address of the
1544 person to whom the claimant should respond and a claim number to
1545 be referenced in future correspondence.

1546 4. Notwithstanding that written notice has been furnished
1547 to the insurer, payment is not overdue if the insurer has
1548 reasonable proof that the insurer is not responsible for the
1549 payment.



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1550 5. For the purpose of calculating the extent to which
1551 benefits are overdue, payment shall be considered made on the
1552 date a draft or other valid instrument that is equivalent to
1553 payment was placed in the United States mail in a properly
1554 addressed, postpaid envelope or, if not so posted, on the date
1555 of delivery.

1556 6. All overdue payments bear simple interest at the rate
1557 established under s. 55.03 or the rate established in the
1558 insurance contract, whichever is greater, for the quarter in
1559 which the payment became overdue, calculated from the date the
1560 insurer was furnished with written notice of the amount of the
1561 covered loss. Interest is due at the time payment of the overdue
1562 claim is made.

1563 (g) If two or more insurers are liable for paying emergency
1564 care coverage benefits for the same injury to any one person,
1565 the maximum amount payable shall be as specified in subsection
1566 (1), and an insurer paying the benefits is entitled to recover
1567 from each of the other insurers an equitable pro rata share of
1568 the benefits paid and expenses incurred in processing the claim.

1569 (h) In a dispute between the insured and the insurer, or
1570 between an assignee of the insured's rights and the insurer, the
1571 insurer must notify the insured or the assignee that the policy
1572 limits under this section have been reached within 15 days after
1573 the limits have been reached.

1574 (i) Benefits are not due or payable to or on behalf of an
1575 insured, claimant, medical provider, or attorney if the insured,
1576 claimant, medical provider, or attorney has:

1577 1. Knowingly submitted a false material statement,
1578 document, record, or bill;



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1579 2. Knowingly submitted false material information; or
1580 3. Otherwise committed or attempted to commit a fraudulent
1581 insurance act as defined in s. 626.989.

1582
1583 A claimant who violates this paragraph is not entitled to any
1584 emergency care coverage benefits or payment for any bills and
1585 services, regardless of whether a portion of the claim may be
1586 legitimate. However, a medical provider who does not violate
1587 this paragraph may not be denied benefits solely due to
1588 violation by another claimant.

1589 (j) If an insurer has a reasonable belief that a fraudulent
1590 insurance act, as defined in s. 626.989, has been committed and
1591 reports its suspicions to the Division of Insurance Fraud, the
1592 30-day period for payment is tolled for any portions of the
1593 claim reported for investigation until the insurer receives
1594 notice from the Division of Insurance Fraud that the claim has
1595 been investigated and states whether a criminal action will be
1596 recommended.

1597 1. The insurer must notify the claimant in writing that the
1598 claim is being investigated for fraud within 30 days after the
1599 insurer is furnished with written notice of the fact and amount
1600 of a covered loss. Within 30 days after receipt of notice from
1601 the Division of Insurance Fraud that a claim has been
1602 investigated and that no criminal action will be recommended,
1603 the insurer must pay the claim with simple interest as provided
1604 in subparagraph (f) 6.

1605 2. Subject to s. 626.989(4), persons or entities that in
1606 good faith report suspected fraud to the Division of Insurance
1607 Fraud or share information in the furtherance of a fraud



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1608 investigation are not subject to any civil or criminal liability
1609 relating to the reporting or release of such information.

1610 (k) It is a violation of the insurance code for an insurer
1611 to fail to timely provide benefits as required by this section
1612 with such frequency as to constitute a general business
1613 practice.

1614 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.-

1615 (a) A physician, hospital, clinic, or other person or
1616 institution lawfully rendering treatment to an injured person
1617 for a bodily injury covered by emergency care coverage insurance
1618 may charge the insurer and injured party only a reasonable
1619 amount pursuant to this section for the services, treatment,
1620 supplies, and care rendered, and the insurer providing such
1621 coverage may pay such charges directly to such person or
1622 institution lawfully rendering such treatment if the insured
1623 receiving such treatment, or her or his guardian, has
1624 countersigned the properly completed invoice, bill, or claim
1625 form approved by the office attesting that such treatment has
1626 actually been rendered to the best knowledge of the insured or
1627 her or his guardian. However, such charge may not exceed the
1628 amount that the person or institution customarily charges for
1629 like services, treatment, supplies, or care. When determining
1630 whether a charge for a particular service, treatment, supply, or
1631 care is reasonable, consideration may be given to evidence of
1632 usual and customary charges and payments accepted by the
1633 provider involved in the dispute, reimbursement levels in the
1634 community and various federal and state medical fee schedules
1635 applicable to motor vehicle and other insurance coverages, and
1636 other information relevant to the reasonableness of the charges



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1637 for the service, treatment, supply, or care.

1638 1. If a health care provider or entity bills an insurer an
1639 amount less than that indicated in the following schedule of
1640 maximum charges and the insurer pays the amount billed, the
1641 payment shall be considered reasonable. A payment made by an
1642 insurer that limits reimbursement to 80 percent of the following
1643 schedule of maximum charges is considered reasonable:

1644 a. For emergency transport and treatment by providers
1645 licensed under chapter 401, 200 percent of Medicare charges.

1646 b. For emergency services and care provided by a hospital,
1647 75 percent of the hospital's usual and customary charges.

1648 c. For emergency services and care provided in a hospital
1649 and rendered by a physician or dentist, and related hospital
1650 inpatient services rendered by a physician or dentist, the usual
1651 and customary charges in the community.

1652 d. For hospital inpatient services, other than emergency
1653 services and care, 200 percent of the Medicare Part A
1654 prospective payment applicable to the specific hospital
1655 providing the inpatient services.

1656 e. For hospital outpatient services, other than emergency
1657 services and care, 200 percent of the Medicare Part A Ambulatory
1658 Payment Classification for the specific hospital providing the
1659 outpatient services.

1660 f. For all other medical services, treatment, supplies, and
1661 care, 200 percent of the allowable amount under:

1662 (I) The participating physicians fee schedule of Medicare
1663 Part B.

1664 (II) For medical services, treatment, supplies, and care
1665 provided by clinical laboratories, Medicare Part B.



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1666 (III) For durable medical equipment, the Durable Medical
1667 Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee
1668 schedule of Medicare Part B.

1669
1670 However, if such services, treatment, supplies, or care is not
1671 reimbursable under Medicare Part B as provided in this sub-
1672 subparagraph, the insurer may limit reimbursement to 80 percent
1673 of the maximum reimbursable allowance under workers'
1674 compensation, as determined under s. 440.13 and rules adopted
1675 thereunder which are in effect at the time such services,
1676 treatment, supplies, or care is provided. Services, treatment,
1677 supplies, or care that is not reimbursable under Medicare or
1678 workers' compensation is not required to be reimbursed by the
1679 insurer.

1680 2. For purposes of subparagraph 1., the applicable fee
1681 schedule or payment limitation under Medicare is the fee
1682 schedule or payment limitation that was in effect on March 1 of
1683 the year and for the area in which the services, treatment,
1684 supplies, or care was rendered, and applies until March 1 of the
1685 following year, notwithstanding subsequent changes made to such
1686 fee schedule or payment limitation, except that it may not be
1687 less than the allowable amount under the participating
1688 physicians schedule of Medicare Part B for 2007 for medical
1689 services, treatment, supplies, and care subject to Medicare Part
1690 B.

1691 3. Subparagraph 1. does not allow the insurer to apply any
1692 limitation on the number of treatments or other utilization
1693 limits that apply under Medicare or workers' compensation. An
1694 insurer that applies the allowable payment limitations of



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1695 subparagraph 1. must reimburse a provider who lawfully provided
1696 care or treatment under the scope of her or his license
1697 regardless of whether such provider is entitled to reimbursement
1698 under Medicare due to restrictions or limitations on the types
1699 or discipline of health care providers who may be reimbursed for
1700 particular procedures or procedure codes. However, subparagraph
1701 1. does not prohibit an insurer from using the Medicare coding
1702 policies and payment methodologies of the Centers for Medicare
1703 and Medicaid Services, including applicable modifiers, to
1704 determine the appropriate amount of reimbursement.

1705 4. If an insurer limits payment as authorized by
1706 subparagraph 1., the person providing such services, treatment,
1707 supplies, or care may not bill or attempt to collect from the
1708 insured any amount in excess of such limits, except for amounts
1709 that are not covered by the insured's emergency care coverage
1710 insurance due to the coinsurance amount or maximum policy
1711 limits.

1712 (b) An insurer or insured is not required to pay a claim or
1713 charges:

1714 1. Made by a broker or by a person making a claim on behalf
1715 of a broker;

1716 2. For any service or treatment that was not lawful at the
1717 time rendered;

1718 3. To any person who knowingly submits a false material
1719 statement relating to the claim or charges;

1720 4. With respect to a bill or statement that does not
1721 substantially meet the applicable requirements of paragraph (d);

1722 5. For any treatment or service that is upcoded, or that is
1723 unbundled when such treatment or services should be bundled, in



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1724 accordance with paragraph (e). To facilitate prompt payment of
1725 lawful services, an insurer may change billing codes that it
1726 determines have been improperly or incorrectly upcoded or
1727 unbundled and may make payment based on the changed billing
1728 codes without affecting the right of the provider to dispute the
1729 change by the insurer. However, before doing that, the insurer
1730 must contact the health care provider and discuss the reasons
1731 for the insurer's change and the health care provider's reason
1732 for the coding or make a reasonable good faith effort to do so
1733 as documented in the insurer's file; or

1734 6. For medical services or treatment billed by a physician
1735 and not provided in a hospital unless such services are rendered
1736 by the physician or are incident to her or his professional
1737 services and included on the physician's bill, including
1738 documentation verifying that the physician is responsible for
1739 the medical services that were rendered and billed.

1740 (c) The Department of Health, in consultation with the
1741 appropriate professional licensing boards, shall adopt by rule a
1742 list of diagnostic tests deemed not to be medically necessary
1743 for use in the treatment of persons sustaining bodily injury
1744 covered by emergency care coverage benefits under this section.
1745 The list shall be revised from time to time as determined by the
1746 Department of Health in consultation with the respective
1747 professional licensing boards. Inclusion of a test on the list
1748 shall be based on lack of demonstrated medical value and a level
1749 of general acceptance by the relevant provider community and may
1750 not be dependent entirely upon subjective patient response.
1751 Notwithstanding its inclusion on a fee schedule in this
1752 subsection, an insurer or insured is not required to pay any



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1753 charges or reimburse claims for any diagnostic test deemed not
1754 medically necessary by the Department of Health.

1755 (d) With respect to any treatment or service, other than
1756 medical services billed by a hospital or other provider for
1757 emergency services and care or inpatient services rendered at a
1758 hospital-owned facility, the statement of charges must be
1759 furnished to the insurer by the provider and may not include,
1760 and the insurer is not required to pay, charges for treatment or
1761 services rendered more than 35 days before the postmark date or
1762 electronic transmission date of the statement, except for past
1763 due amounts previously billed on a timely basis under this
1764 paragraph. However, if the provider submits to the insurer a
1765 notice of initiation of treatment within 21 days after its first
1766 examination or treatment of the claimant, the statement may
1767 include charges for treatment or services rendered up to, but
1768 not more than, 75 days before the postmark date of the
1769 statement. The injured party is not liable for, and the provider
1770 may not bill the injured party for, charges that are unpaid
1771 because of the provider's failure to comply with this paragraph.
1772 Any agreement requiring the injured person or insured to pay for
1773 such charges is unenforceable.

1774 1. If the insured fails to furnish the provider with the
1775 correct name and address of the insured's emergency care
1776 coverage insurer, the provider has 35 days after the date the
1777 provider obtains the correct information to furnish the insurer
1778 with a statement of the charges. The insurer is not required to
1779 pay for such charges unless the provider includes with the
1780 statement documentary evidence that was provided by the insured
1781 during the 35-day period which demonstrates that the provider



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1782 reasonably relied on erroneous information from the insured and:

1783 a. A denial letter from the incorrect insurer; or

1784 b. Proof of mailing, which may include an affidavit under
1785 penalty of perjury reflecting timely mailing to the incorrect
1786 address or insurer.

1787 2. For emergency services and care rendered in a hospital
1788 emergency department or for transport and treatment rendered by
1789 an ambulance provider licensed pursuant to part III of chapter
1790 401, the provider is not required to furnish the statement of
1791 charges within the time period established by this paragraph,
1792 and the insurer is not considered to have been furnished with
1793 notice of the amount of the covered loss for purposes of
1794 paragraph (4) (f) until it receives a statement complying with
1795 paragraph (e), or a copy thereof, which specifically identifies
1796 the place of service as a hospital emergency department or an
1797 ambulance in accordance with billing standards recognized by the
1798 federal Centers for Medicare and Medicaid Services.

1799 3. Each notice of the insured's rights under s. 627.7488
1800 must include the following statement in at least 12-point type:

1801
1802 BILLING REQUIREMENTS.—Florida law provides that with
1803 respect to any treatment or services, other than
1804 certain hospital and emergency services, the statement
1805 of charges furnished to the insurer by the provider
1806 may not include, and the insurer and the injured party
1807 are not required to pay, charges for treatment or
1808 services rendered more than 35 days before the
1809 postmark date of the statement, except for past due
1810 amounts previously billed on a timely basis, and



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1811 except that, if the provider submits to the insurer a
1812 notice of initiation of treatment within 21 days after
1813 its first examination or treatment of the claimant,
1814 the statement may include charges for treatment or
1815 services rendered up to, but not more than, 75 days
1816 before the postmark date of the statement.

1817
1818 (e) All statements and bills for medical services rendered
1819 by a physician, hospital, clinic, or other person or institution
1820 shall be submitted to the insurer on a properly completed
1821 Centers for Medicare and Medicaid Services (CMS) 1500 form, UB
1822 92 form, or any other standard form approved by the office or
1823 adopted by the commission for purposes of this paragraph. All
1824 billings for such services rendered by providers must, to the
1825 extent applicable, follow the Physicians' Current Procedural
1826 Terminology (CPT) or Healthcare Correct Procedural Coding System
1827 (HCPCS), or ICD-9 in effect for the year in which services are
1828 rendered and comply with the CMS 1500 form instructions, the
1829 American Medical Association CPT Editorial Panel and the HCPCS.
1830 All providers, other than hospitals, must include on the
1831 applicable claim form the professional license number of the
1832 provider in the line or space provided for "Signature of
1833 Physician or Supplier, Including Degrees or Credentials." In
1834 determining compliance with applicable CPT and HCPCS coding,
1835 guidance shall be provided by the CPT or HCPCS in effect for the
1836 year in which services were rendered, the Office of the
1837 Inspector General, Physicians Compliance Guidelines, and other
1838 authoritative treatises designated by rule by the Agency for
1839 Health Care Administration. A statement of medical services may



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1840 not include charges for the medical services of a person or
1841 entity that performed such services without possessing the valid
1842 licenses required to perform such services. For purposes of
1843 paragraph (4) (f), an insurer is not considered to have been
1844 furnished with notice of the amount of the covered loss or
1845 medical bills due unless the statements or bills comply with
1846 this paragraph and are properly completed in their entirety as
1847 to all material provisions, with all relevant information being
1848 provided therein.

1849 (f)1. At the time the initial treatment or service is
1850 provided, each physician, licensed professional, clinic, or
1851 medical institution providing medical services upon which a
1852 claim for benefits is based shall require an insured person or
1853 her or his guardian to execute a disclosure and acknowledgment
1854 form that reflects at a minimum that:

1855 a. The insured or her or his guardian must countersign the
1856 form attesting to the fact that the services set forth in the
1857 form were actually rendered.

1858 b. The insured or her or his guardian has both the right
1859 and the affirmative duty to confirm that the services were
1860 actually rendered.

1861 c. The insured or her or his guardian was not solicited by
1862 any person to seek any services from the medical provider.

1863 d. The physician, other licensed professional, clinic, or
1864 other medical institution rendering services for which payment
1865 is being claimed explained the services to the insured or her or
1866 his guardian.

1867 e. If the insured notifies the insurer in writing of a
1868 billing error, the insured may be entitled to a certain



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1869 percentage of any reduction in the amounts paid by the insured's
1870 motor vehicle insurer.

1871 2. The physician, other licensed professional, clinic, or
1872 other medical institution rendering services for which payment
1873 is being claimed has the affirmative duty to explain the
1874 services rendered to the insured or her or his guardian so that
1875 the insured or her or his guardian countersigns the form with
1876 informed consent.

1877 3. Countersignature by the insured or her or his guardian
1878 is not required for the reading of diagnostic tests or other
1879 services that are not required to be performed in the presence
1880 of the insured.

1881 4. The licensed medical professional rendering treatment
1882 for which payment is being claimed must, by her or his own hand,
1883 sign the form complying with this paragraph.

1884 5. The completed original disclosure and acknowledgment
1885 form shall be furnished to the insurer pursuant to paragraph
1886 (4) (f) and may not be electronically furnished.

1887 6. The disclosure and acknowledgment form is not required
1888 for services billed by a provider for emergency services and
1889 care rendered in a hospital emergency department or for
1890 transport and treatment rendered by an ambulance provider
1891 licensed pursuant to part III of chapter 401.

1892 7. The Financial Services Commission shall adopt a standard
1893 disclosure and acknowledgment form by rule to fulfill the
1894 requirements of this paragraph.

1895 8. As used in this paragraph, the term "countersign" or
1896 "countersignature" means bearing a second or verifying
1897 signature, as on a previously signed document, and is not



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1898 satisfied by the statement "signature on file" or similar
1899 statement.

1900 9. This paragraph applies only with respect to the initial
1901 treatment or service of the insured by a provider. For
1902 subsequent treatments or service, the provider must maintain a
1903 patient log signed by the patient, in chronological order by
1904 date of service, which is consistent with the services being
1905 rendered to the patient as claimed. The requirement to maintain
1906 a patient log signed by the patient may be met by a hospital
1907 that maintains medical records as required by s. 395.3025 and
1908 applicable rules and makes such records available to the insurer
1909 upon request.

1910 (g) Upon written notification by any person, an insurer
1911 shall investigate any claim of improper billing by a physician
1912 or other medical provider. The insurer shall determine whether
1913 the insured was properly billed for only those services and
1914 treatments that the insured actually received. If the insurer
1915 determines that the insured has been improperly billed, the
1916 insurer shall notify the insured, the person making the written
1917 notification, and the provider of its findings and reduce the
1918 amount of payment to the provider by the amount determined to be
1919 improperly billed. If a reduction is made due to a written
1920 notification by any person, the insurer shall pay to that person
1921 20 percent of the amount of the reduction, up to \$500. If the
1922 provider is arrested due to the improper billing, the insurer
1923 shall pay to that person 40 percent of the amount of the
1924 reduction, up to \$500.

1925 (h) An insurer may not systematically downcode with the
1926 intent to deny reimbursement otherwise due. Such action



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1927 constitutes a material misrepresentation under s.
1928 626.9541(1)(i)2.

1929 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

1930 (a) In all circumstances, an insured seeking under ss.
1931 627.748-627.7491, including omnibus insureds, must comply with
1932 the terms of the policy. Compliance with this paragraph is a
1933 condition precedent to the insured's recovering of benefits,
1934 except that an insured may not be required to submit to an
1935 examination under oath. If a request is made by an insurer
1936 providing emergency care coverage against whom a claim has been
1937 made, an employer must furnish a sworn statement, in a form
1938 approved by the office, of the earnings of the person upon whose
1939 injury the claim is based since the time of the bodily injury
1940 and for a reasonable period before the injury.

1941 (b) If an insured seeking to recover benefits pursuant to
1942 ss. 627.748-627.7491 assigns the contractual right to such
1943 benefits or payment of such benefits to any person or entity,
1944 the assignee must comply with the terms of the policy. In all
1945 circumstances, the assignee is obligated to cooperate under the
1946 policy, except that an assignee may not be required to submit to
1947 an examination under oath.

1948 (c) All claimants must produce and allow for the inspection
1949 of all documents requested by the insurer which are relevant to
1950 the services rendered and reasonably obtainable by the claimant.

1951 (d) Each physician, hospital, clinic, or other medical
1952 institution providing, before or after bodily injury upon which
1953 a claim for emergency care coverage is based, any products,
1954 services, or accommodations relating to that or any other
1955 injury, or to a condition claimed to be connected with that or



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1956 any other injury, shall, if requested by the insurer against
1957 whom the claim has been made, permit the insurer or the
1958 insurer's representative to conduct, within 10 days after the
1959 insurer's request, an onsite physical review and examination of
1960 the treatment location, treatment apparatuses, diagnostic
1961 devices, and any other medical equipment used for the services
1962 rendered, and shall furnish a written report of the history,
1963 condition, treatment, dates, and costs of such treatment of the
1964 injured person and why the items identified by the insurer were
1965 reasonable in amount and medically necessary. The report shall
1966 be furnished with a sworn statement that the treatment or
1967 services rendered were reasonable and necessary with respect to
1968 the bodily injury sustained and must identify which portion of
1969 the expenses for the treatment or services was incurred as a
1970 result of the bodily injury. The physician, hospital, clinic, or
1971 other medical institution shall also permit the inspection and
1972 copying of any records regarding such history, condition,
1973 treatment, dates, and costs of treatment; however, this does not
1974 limit the introduction of evidence at trial. The sworn statement
1975 must read as follows: "Under penalty of perjury, I declare that
1976 I have read the foregoing, and the facts alleged are true to the
1977 best of my knowledge and belief."

1978
1979 A cause of action for violation of the physician-patient
1980 privilege or invasion of the right of privacy is prohibited
1981 against any physician, hospital, clinic, or other medical
1982 institution complying with this paragraph. The person requesting
1983 such records and sworn statement shall pay all reasonable costs
1984 connected therewith. If an insurer makes a written request for



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1985 documentation or information within 30 days after having
1986 received notice of the amount of a covered loss under paragraph
1987 (4) (f), the amount or the partial amount that is the subject of
1988 the insurer's inquiry is overdue if the insurer does not pay in
1989 accordance with paragraph (4) (f) or within 10 days after the
1990 insurer's receipt of the requested documentation or information,
1991 whichever occurs later. As used in this paragraph, the term
1992 "receipt" includes, but is not limited to, inspection and
1993 copying pursuant to this paragraph. An insurer that requests
1994 documentation or information pertaining to the reasonableness of
1995 charges or medical necessity without a reasonable basis for such
1996 requests as a general business practice is engaging in an unfair
1997 trade practice under the insurance code. Section 626.989(4) (d)
1998 applies to the sharing of information related to reviews and
1999 examinations conducted pursuant to this section.

2000 (e) If there is a dispute regarding an insurer's right to
2001 discovery of facts under this section, the insurer may petition
2002 the court to enter an order permitting such discovery. The order
2003 may be made only on motion for good cause shown and upon notice
2004 to all persons having an interest, and must specify the time,
2005 place, manner, conditions, and scope of the discovery. The court
2006 may, in order to protect against annoyance, embarrassment, or
2007 oppression, as justice requires, enter an order refusing
2008 discovery or specifying conditions of discovery and may order
2009 payments of costs and expenses of the proceeding, including
2010 reasonable fees for the appearance of attorneys at the
2011 proceedings, as justice requires.

2012 (f) Upon request, the injured person shall be furnished a
2013 copy of all information obtained by the insurer under this



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2014 section and shall pay a reasonable charge if required by the
2015 insurer.

2016 (g) Notice to an insurer of the existence of a claim may
2017 not be unreasonably withheld by an insured.

2018 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
2019 REPORTS.—If the mental or physical condition of an injured
2020 person covered by emergency care coverage is material to a claim
2021 that has been or may be made for past or future benefits under
2022 such coverage, upon the request of an insurer, such person must
2023 submit to mental or physical examination by a physician. The
2024 costs of such examination shall be borne entirely by the
2025 insurer. The insurer may include reasonable provisions in
2026 emergency care coverage insurance policies for the mental and
2027 physical examination of those claiming benefits under the
2028 policy.

2029 (a) The examination must be conducted within the
2030 municipality where the insured is receiving treatment, or in a
2031 location reasonably accessible to the insured, which means any
2032 location within the municipality in which the insured resides,
2033 or within 10 miles by road of the insured's residence if such
2034 location is within the county in which the insured resides. If
2035 the examination is to be conducted in a location reasonably
2036 accessible to the insured but there is no qualified physician to
2037 conduct the examination in such location, the examination shall
2038 be conducted in an area that is in the closest proximity to the
2039 insured's residence.

2040 (b) An insurer may not withdraw payment from a treating
2041 physician without the consent of the injured person covered by
2042 the policy unless the insurer first obtains a valid report by a



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2043 Florida physician licensed under the same chapter as the
2044 treating physician stating that treatment was not reasonable,
2045 related, or necessary. A valid report is one that is prepared
2046 and signed by the physician examining the injured person or who
2047 reviewed the treatment records of the injured person, is
2048 factually supported by the examination or treatment records
2049 reviewed, and that has not been modified by anyone other than
2050 the reviewing physician. The physician preparing the report must
2051 be in active practice, unless he or she is physically disabled.
2052 "Active practice" means that during the 3 years immediately
2053 preceding the date of the physical examination or review of
2054 treatment records, the physician devoted professional time to
2055 the active clinical practice of evaluation, diagnosis, or
2056 treatment of medical conditions or to the instruction of
2057 students in an accredited health professional school, accredited
2058 residency program, or a clinical research program that is
2059 affiliated with an accredited health professional school,
2060 teaching hospital, or accredited residency program. The insurer
2061 and any person acting at the direction of or on behalf of the
2062 insurer may not materially change an opinion in a report
2063 prepared under this paragraph or direct the physician preparing
2064 the report to change such opinion. The denial of a payment
2065 resulting from a changed opinion constitutes a material
2066 misrepresentation under s. 626.9541(1)(i)2. This provision does
2067 not preclude the insurer from calling to the physician's
2068 attention any errors of fact in the report based upon
2069 information in the claim file.

2070 (c) If requested by the person examined, a party causing an
2071 examination to be made must deliver a copy of every written



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2072 report concerning a examination rendered by an examining
2073 physician to the person examined, at least one of which must set
2074 out the examining physician's findings and conclusions in
2075 detail. After such request and delivery, the party causing the
2076 examination to be made is entitled, upon request, to receive
2077 from the person examined every written report available to him
2078 or her or his or her representative concerning any examination,
2079 previously or thereafter made, of the same mental or physical
2080 condition. By requesting and obtaining a report of the
2081 examination so ordered, or by taking the deposition of the
2082 examiner, the person examined waives any privilege he or she may
2083 have, relating to the claim for benefits, regarding the
2084 testimony of every other person who has examined, or may
2085 thereafter examine, him or her with respect to the same mental
2086 or physical condition.

2087 (d) The physician preparing a report at the request of an
2088 insurer and physicians rendering expert opinions on behalf of
2089 persons claiming medical benefits for emergency care coverage,
2090 or on behalf of an insured through an attorney or another
2091 entity, must maintain copies of all examination reports as
2092 medical records and all payments for the examinations and
2093 reports for at least 3 years.

2094 (e) If a person unreasonably refuses to submit to an
2095 examination or fails to appear for an examination, the insurer
2096 is no longer liable for subsequent emergency care benefits.
2097 Refusal or failure to appear for two examinations raises a
2098 rebuttable presumption that such refusal or failure was
2099 unreasonable.

2100 (8) DEMAND LETTER.-



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2101 (a) As a condition precedent to filing an action for
2102 benefits under this section, the insurer must be provided with
2103 written notice of an intent to initiate litigation. Such notice
2104 may not be sent until the claim is overdue, including any
2105 additional time the insurer has to pay the claim pursuant to
2106 subsection (4).

2107 (b) The notice required must state that it is a "demand
2108 letter under s. 627.7485(8), F.S.," and state with specificity:

2109 1. The name of the insured upon whom such benefits are
2110 being sought, including a copy of the assignment giving rights
2111 to the claimant if the claimant is not the insured.

2112 2. The claim number or policy number upon which such claim
2113 was originally submitted to the insurer.

2114 3. To the extent applicable, the name of any medical
2115 provider who rendered the treatment, services, accommodations,
2116 or supplies to an insured which form the basis of such claim and
2117 an itemized statement specifying each exact amount, the date of
2118 treatment, service, or accommodation, and the type of benefit
2119 claimed to be due. A completed form satisfying the requirements
2120 of paragraph (5)(e) or the lost-wage statement previously
2121 submitted may be used as the itemized statement. If the demand
2122 involves an insurer's withdrawal of payment under paragraph
2123 (7)(b) for future treatment not yet rendered, the claimant shall
2124 attach a copy of the insurer's notice withdrawing such payment
2125 and an itemized statement of the type, frequency, and duration
2126 of future treatment claimed to be reasonable and medically
2127 necessary.

2128 (c) Each notice required by this subsection must be
2129 delivered to the insurer by United States certified or



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2130 registered mail, return receipt requested. If requested by the
2131 claimant in the notice, such postal costs shall be reimbursed by
2132 the insurer when the insurer pays the claim. The notice must be
2133 sent to the person and address specified by the insurer for the
2134 purposes of receiving notices under this subsection. Each
2135 licensed insurer, whether domestic, foreign, or alien, shall
2136 file with the office the name and address of the person to whom
2137 notices pursuant to this subsection are sent, which the office
2138 shall make available on its website. The name and address on
2139 file with the office pursuant to s. 624.422 shall be deemed the
2140 authorized representative to accept notice pursuant to this
2141 subsection if no other designation has been made.

2142 (d) If the overdue claim specified in the notice is paid by
2143 the insurer within 30 days after receipt of notice by the
2144 insurer, plus applicable interest and a penalty of 10 percent of
2145 the overdue amount, subject to a maximum penalty of \$250, no
2146 action may be brought against the insurer. If the demand
2147 involves an insurer's withdrawal of payment under paragraph
2148 (7) (b) for future treatment not yet rendered, no action may be
2149 brought against the insurer if, within 30 days after receipt of
2150 the notice, the insurer mails to the person filing the notice a
2151 written statement of the insurer's agreement to pay for such
2152 treatment in accordance with the notice and to pay a penalty of
2153 10 percent, subject to a maximum penalty of \$250, when it pays
2154 for such future treatment in accordance with the requirements of
2155 this section. To the extent the insurer determines not to pay
2156 any amount demanded, the penalty is not payable in any
2157 subsequent action. For purposes of this paragraph, payment or
2158 the insurer's agreement are considered made on the date a draft



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2159 or other valid instrument that is equivalent to payment, or the
2160 insurer's written statement of agreement, is placed in the
2161 United States mail in a properly addressed, postpaid envelope,
2162 or if not so posted, on the date of delivery. The insurer is not
2163 obligated to pay any attorney fees if the insurer pays the claim
2164 or mails its agreement to pay for future treatment within the
2165 time prescribed by this paragraph.

2166 (e) The applicable statute of limitation for an action
2167 under this section shall be tolled for 30 business days by the
2168 mailing of the notice required by this subsection.

2169 (f) Any insurer making a general business practice of not
2170 paying valid claims until receipt of the notice required by this
2171 subsection is engaging in an unfair trade practice under the
2172 insurance code.

2173 (9) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
2174 PRACTICE.—

2175 (a) If an insurer fails to pay valid claims for emergency
2176 care coverage with such frequency as to indicate a general
2177 business practice, the insurer is engaging in a prohibited
2178 unfair or deceptive practice subject to the penalties provided
2179 in s. 626.9521, and the office has the powers and duties
2180 specified in ss. 626.9561-626.9601 with respect thereto.

2181 (b) Notwithstanding s. 501.212, the Department of Legal
2182 Affairs may investigate and initiate actions for a violation of
2183 this subsection, including, but not limited to, the powers and
2184 duties specified in part II of chapter 501.

2185 (10) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall
2186 have a cause of action against any person convicted of, or who,
2187 regardless of adjudication of guilt, pleads guilty or nolo



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2188 contendere to, insurance fraud under s. 817.234, patient
2189 brokering under s. 817.505, or kickbacks under s. 456.054,
2190 associated with a claim for emergency care coverage in
2191 accordance with this section. An insurer prevailing in an action
2192 brought under this subsection may recover compensatory,
2193 consequential, and punitive damages subject to the requirements
2194 and limitations of part II of chapter 768 and attorney fees and
2195 costs incurred in litigating the cause of action.

2196 (11) FRAUD ADVISORY NOTICE.—Upon receiving notice of a
2197 claim under this section, an insurer shall provide a notice to
2198 the insured or to a person for whom a claim for reimbursement
2199 for diagnosis or treatment of injuries has been filed advising
2200 that:

2201 (a) Pursuant to s. 626.9892, the Department of Financial
2202 Services may pay rewards of up to \$25,000 to persons providing
2203 information leading to the arrest and conviction of persons
2204 committing crimes investigated by the Division of Insurance
2205 Fraud arising from violations of s. 440.105, s. 624.15, s.
2206 626.9541, s. 626.989, or s. 817.234.

2207 (b) Solicitation of a person injured in a motor vehicle
2208 crash for purposes of filing emergency care coverage or tort
2209 claims could be a violation of s. 817.234 or s. 817.505 or the
2210 rules regulating The Florida Bar and, if such conduct has taken
2211 place, should be immediately reported to the Division of
2212 Insurance Fraud.

2213 (12) ALL CLAIMS BROUGHT IN A SINGLE ACTION.—In any civil
2214 action to recover emergency care coverage brought by a claimant
2215 pursuant to this section against an insurer, all claims related
2216 to the same health care provider for the same injured person



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2217 shall be brought in one action unless good cause is shown why
2218 such claims should be brought separately. If the court
2219 determines that a civil action is filed for a claim that should
2220 have been brought in a prior civil action, the court may not
2221 award attorney fees to the claimant.

2222 (13) SECURE ELECTRONIC DATA TRANSFER.—A notice,
2223 documentation, transmission, or communication of any kind
2224 required or authorized under ss. 627.748-627.7491 may be
2225 transmitted electronically if it is transmitted by secure
2226 electronic data transfer that is consistent with state and
2227 federal privacy and security laws.

2228 Section 15. Section 627.7486, Florida Statutes, is created
2229 to read:

2230 627.7486 Tort exemption; limitation on right to damages;
2231 punitive damages.—

2232 (1) Every owner, registrant, operator, or occupant of a
2233 motor vehicle for which security has been provided as required
2234 by ss. 627.748-627.7491, and every person or organization
2235 legally responsible for her or his acts or omissions, is exempt
2236 from tort liability for damages because of bodily injury,
2237 sickness, or disease arising out of the ownership, operation,
2238 maintenance, or use of such motor vehicle in this state to the
2239 extent that the benefits described in s. 627.7485(1) are payable
2240 for such injury, or would be payable but for any exclusion
2241 authorized by ss. 627.748-627.7491, under any insurance policy
2242 or other method of security complying with s. 627.7483, or by an
2243 owner personally liable under s. 627.7483 for the payment of
2244 such benefits, unless the person is entitled to maintain an
2245 action for pain, suffering, mental anguish, and inconvenience



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2246 for such injury under subsection (2).

2247 (2) In any action of tort brought against the owner,
2248 registrant, operator, or occupant of a motor vehicle for which
2249 security has been provided as required by ss. 627.748-627.7491,
2250 or against any person or organization legally responsible for
2251 her or his acts or omissions, a plaintiff may recover damages in
2252 tort for pain, suffering, mental anguish, and inconvenience
2253 because of bodily injury, sickness, or disease arising out of
2254 the ownership, maintenance, operation, or use of such motor
2255 vehicle only if the injury or disease consists in whole or in
2256 part of:

2257 (a) Significant and permanent loss of an important bodily
2258 function;

2259 (b) Permanent injury within a reasonable degree of medical
2260 probability, other than scarring or disfigurement;

2261 (c) Significant and permanent scarring or disfigurement; or

2262 (d) Death.

2263 (3) If a defendant in a proceeding brought pursuant to ss.
2264 627.748-627.7491 questions whether the plaintiff has met the
2265 requirements of subsection (2), the defendant may file an
2266 appropriate motion with the court, and the court, 30 days before
2267 the date set for the trial or the pretrial hearing, whichever is
2268 first, shall, on a one-time basis only, ascertain by examining
2269 the pleadings and the evidence before it whether the plaintiff
2270 will be able to submit some evidence that the plaintiff will
2271 meet the requirements of subsection (2). If the court finds that
2272 the plaintiff will not be able to submit such evidence, the
2273 court shall dismiss the plaintiff's claim without prejudice.

2274 (4) A claim for punitive damages is not allowed in any



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2275 action brought against a motor vehicle liability insurer for
2276 damages in excess of its policy limits.

2277 Section 16. Section 627.7487, Florida Statutes, is created
2278 to read:

2279 627.7487 Emergency care coverage; optional limitations;
2280 deductibles.-

2281 (1) The named insured may elect a deductible or modified
2282 coverage or combination thereof to apply to the named insured
2283 alone or to the named insured and dependent relatives residing
2284 in the insured's household but may not elect a deductible or
2285 modified coverage to apply to any other person covered under the
2286 policy.

2287 (2) Upon the renewal of an existing policy, an insurer
2288 shall offer deductibles of \$250, \$500, and \$1,000 to each
2289 applicant and to each policyholder. The deductible amount must
2290 be applied to 100 percent of the expenses and losses described
2291 in s. 627.7485. After the deductible is met, each insured may
2292 receive up to \$10,000 in total benefits as described in s.
2293 627.7485(1). However, this subsection may not be applied to
2294 reduce the amount of any benefits received in accordance with s.
2295 627.7485(1)(c).

2296 (3) An insurer shall offer coverage where, at the election
2297 of the named insured, the benefits for loss of gross income and
2298 loss of earning capacity described in s. 627.7485(1)(b) are
2299 excluded.

2300 (4) The named insured may not be prevented from electing a
2301 deductible under subsection (2) and modified coverage under
2302 subsection (3). Each election made by the named insured under
2303 this section must result in an appropriate reduction of premium



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2304 associated with that election.

2305 (5) All such offers must be made in clear and unambiguous
2306 language at the time the initial application is taken and before
2307 each annual renewal and indicate that a premium reduction will
2308 result from each election. At the option of the insurer, such
2309 requirement may be met by using forms of notice approved by the
2310 office or by providing the following notice in 10-point type in
2311 the insurer's application for initial issuance of a policy of
2312 motor vehicle insurance and the insurer's annual notice of
2313 renewal premium:

2314
2315 For emergency care coverage insurance, the named insured may
2316 elect a deductible and may choose to exclude coverage for loss
2317 of gross income and loss of earning capacity ("lost wages").
2318 This selection and choice apply to the named insured alone, or
2319 to the named insured and all dependent resident relatives. A
2320 premium reduction will result from these elections. The named
2321 insured is hereby advised not to elect the lost wage exclusion
2322 if the named insured or dependent resident relatives are
2323 employed, since lost wages will not be payable in the event of
2324 an accident.

2325 Section 17. Section 627.7488, Florida Statutes, is created
2326 to read:

2327 627.7488 Notice of insured's rights.-

2328 (1) The commission shall adopt by rule a form for notifying
2329 insureds of their right to receive coverage under the Florida
2330 Motor Vehicle No-Fault Emergency Care Coverage Law. Such notice
2331 must include:

2332 (a) A description of the benefits provided, including, but



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2333 not limited to, the specific types of services for which medical
2334 benefits are paid, disability benefits, death benefits,
2335 significant exclusions from and limitations on coverage, how
2336 benefits are coordinated with other insurance benefits that the
2337 insured may have, when payments are due, penalties and interest
2338 that may be imposed on insurers for failure to make timely
2339 payments of benefits, and rights of parties regarding disputes
2340 as to benefits.

2341 (b) An advisory informing insureds that:

2342 1. Pursuant to s. 626.9892, the Department of Financial
2343 Services may pay rewards of up to \$25,000 to persons providing
2344 information leading to the arrest and conviction of persons
2345 committing crimes investigated by the Division of Insurance
2346 Fraud arising from violations of s. 440.105, s. 624.15, s.
2347 626.9541, s. 626.989, or s. 817.234.

2348 2. Pursuant to s. 627.7485(5)(f)1.e., if the insured
2349 notifies the insurer in writing of a billing error, the insured
2350 may be entitled to a certain percentage of a reduction in the
2351 amounts paid by the insured's motor vehicle insurer.

2352 (c) A notice that solicitation of a person injured in a
2353 motor vehicle crash for purposes of filing emergency care
2354 coverage or tort claims could be a violation of s. 817.234 or s.
2355 817.505 or the rules regulating The Florida Bar and, if such
2356 conduct has taken place, it should be immediately reported to
2357 the Division of Insurance Fraud.

2358 (2) Each insurer issuing a policy in this state providing
2359 emergency care coverage must mail or deliver the notice as
2360 specified in subsection (1) to an insured within 21 days after
2361 receiving from the insured notice of a motor vehicle accident or



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2362 claim involving personal injury to an insured who is covered
2363 under the policy. The office may allow an insurer additional
2364 time, not to exceed 30 days, to provide the notice specified in
2365 subsection (1) upon a showing by the insurer that an emergency
2366 justifies an extension of time.

2367 (3) The notice required by this section does not alter or
2368 modify the terms of the insurance contract or other requirements
2369 of ss. 627.748-627.7491.

2370 Section 18. Section 627.7489, Florida Statutes, is created
2371 to read:

2372 627.7489 Mandatory joinder of derivative claim.-In any
2373 action brought pursuant to s. 627.7486 claiming personal
2374 injuries, all claims arising out of the plaintiff's injuries,
2375 including all derivative claims, shall be brought together,
2376 unless good cause is shown why such claims should be brought
2377 separately.

2378 Section 19. Section 627.749, Florida Statutes, is created
2379 to read:

2380 627.749 Insurers' right of reimbursement.-Notwithstanding
2381 any other provisions of ss. 627.748-627.7491, an insurer
2382 providing emergency care coverage on a private passenger motor
2383 vehicle shall, to the extent of any emergency care coverage paid
2384 to any person as a benefit arising out of such private passenger
2385 motor vehicle insurance, have a right of reimbursement against
2386 the owner or the insurer of the owner of a commercial motor
2387 vehicle if the benefits paid result from such person having been
2388 an occupant of the commercial motor vehicle or having been
2389 struck by the commercial motor vehicle while not an occupant of
2390 any self-propelled vehicle.



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2391 Section 20. Section 627.7491, Florida Statutes, is created
2392 to read:

2393 627.7491 Application of the Florida Motor Vehicle No-Fault
2394 Emergency Care Coverage Law.-

2395 (1) On or after January 1, 2013, any person subject to ss.
2396 627.748-627.7491 must maintain security for emergency care
2397 coverage.

2398 (2) All forms and rates for policies issued or renewed on
2399 or after January 1, 2013, must reflect ss. 627.748-627.7491 and
2400 must be approved by the office before use.

2401 (3) After January 1, 2013, insurers must provide notice of
2402 the Florida Motor Vehicle No-Fault Emergency Care Coverage Law
2403 to existing policyholders at least 30 days before the policy
2404 expiration date and to applicants for no-fault coverage upon
2405 receipt of the application. The notice is not subject to
2406 approval by the office and must clearly inform the policyholder
2407 or applicant of the following:

2408 (a) That no-fault motor vehicle insurance requirements are
2409 governed by the Florida Motor Vehicle No-Fault Emergency Care
2410 Coverage Law and must provide an explanation of emergency care
2411 coverage. With respect to the initial renewal after January 1,
2412 2013, current policyholders must also be provided with an
2413 explanation of differences between their current policies and
2414 the coverage provided under emergency care coverage policies.

2415 (b) That failure to maintain required emergency care
2416 coverage and \$10,000 in property damage liability coverage may
2417 result in state suspension of the policyholder's driver license
2418 and vehicle registration.

2419 (c) The name and telephone number of a person to contact



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2420 with any questions she or he may have.

2421 Section 21. Subsection (1), paragraph (c) of subsection
2422 (7), paragraphs (a), (b), and (c) of subsection (8), and
2423 subsections (9), (10), and (13) of section 817.234, Florida
2424 Statutes, are amended to read:

2425 817.234 False and fraudulent insurance claims.—

2426 (1) (a) A person commits insurance fraud punishable as
2427 provided in subsection (11) if that person, with the intent to
2428 injure, defraud, or deceive any insurer:

2429 1. Presents or causes to be presented any written or oral
2430 statement as part of, or in support of, a claim for payment or
2431 other benefit pursuant to an insurance policy or a health
2432 maintenance organization subscriber or provider contract,
2433 knowing that such statement contains any false, incomplete, or
2434 misleading information concerning any fact or thing material to
2435 such claim;

2436 2. Prepares or makes any written or oral statement that is
2437 intended to be presented to any insurer in connection with, or
2438 in support of, any claim for payment or other benefit pursuant
2439 to an insurance policy or a health maintenance organization
2440 subscriber or provider contract, knowing that such statement
2441 contains any false, incomplete, or misleading information
2442 concerning any fact or thing material to such claim; ~~or~~

2443 3.a. Knowingly presents, causes to be presented, or
2444 prepares or makes with knowledge or belief that it will be
2445 presented to any insurer, purported insurer, servicing
2446 corporation, insurance broker, or insurance agent, or any
2447 employee or agent thereof, any false, incomplete, or misleading
2448 information or written or oral statement as part of, or in



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2449 support of, an application for the issuance of, or the rating
2450 of, any insurance policy, or a health maintenance organization
2451 subscriber or provider contract; or

2452 b. ~~Who~~ Knowingly conceals information concerning any fact
2453 material to such application; ~~or-~~

2454 4. Knowingly presents, causes to be presented, or, with
2455 knowledge or belief that it will be presented to an insurer,
2456 prepares or makes a claim for payment or other benefit under a
2457 personal injury protection insurance policy or an emergency care
2458 overage insurance policy and the person knows that the payee
2459 knowingly submitted a false, misleading, or fraudulent
2460 application or other document when applying for licensure as a
2461 health care clinic, seeking an exemption from licensure as a
2462 health care clinic, or demonstrating compliance with part X of
2463 chapter 400.

2464 (b) All claims and application forms must ~~shall~~ contain a
2465 statement that is approved by the Office of Insurance Regulation
2466 of the Financial Services Commission which clearly states in
2467 substance the following: "Any person who knowingly and with
2468 intent to injure, defraud, or deceive any insurer files a
2469 statement of claim or an application containing any false,
2470 incomplete, or misleading information is guilty of a felony of
2471 the third degree." This paragraph does ~~shall~~ not apply to
2472 reinsurance contracts, reinsurance agreements, or reinsurance
2473 claims transactions.

2474 (7)

2475 (c) An insurer, or any person acting at the direction of or
2476 on behalf of an insurer, may not change an opinion in a mental
2477 or physical report prepared under s. 627.736(7) or s.



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2478 627.7485(7), as applicable, ~~s. 627.736(8)~~ or direct the
2479 physician preparing the report to change such opinion; however,
2480 this provision does not preclude the insurer from calling to the
2481 attention of the physician errors of fact in the report based
2482 upon information in the claim file. Any person who violates this
2483 paragraph commits a felony of the third degree, punishable as
2484 provided in s. 775.082, s. 775.083, or s. 775.084.

2485 (8) (a) It is unlawful for any person intending to defraud
2486 any other person to solicit or cause to be solicited any
2487 business from a person involved in a motor vehicle accident for
2488 the purpose of making, adjusting, or settling motor vehicle tort
2489 claims or claims for personal injury protection or emergency
2490 care coverage benefits required by s. 627.736 or 627.7485, as
2491 applicable. Any person who violates ~~the provisions of this~~
2492 paragraph commits a felony of the second degree, punishable as
2493 provided in s. 775.082, s. 775.083, or s. 775.084. A person who
2494 is convicted of a violation of this subsection shall be
2495 sentenced to a minimum term of imprisonment of 2 years.

2496 (b) A person may not solicit or cause to be solicited any
2497 business from a person involved in a motor vehicle accident by
2498 any means of communication other than advertising directed to
2499 the public for the purpose of making motor vehicle tort claims
2500 or claims for personal injury protection or emergency care
2501 coverage benefits required by s. 627.736 or 627.7485, as
2502 applicable, within 60 days after the occurrence of the motor
2503 vehicle accident. Any person who violates this paragraph commits
2504 a felony of the third degree, punishable as provided in s.
2505 775.082, s. 775.083, or s. 775.084.

2506 (c) A lawyer, health care practitioner as defined in s.



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2507 456.001, or owner or medical director of a clinic required to be
2508 licensed pursuant to s. 400.9905 may not, at any time after 60
2509 days have elapsed from the occurrence of a motor vehicle
2510 accident, solicit or cause to be solicited any business from a
2511 person involved in a motor vehicle accident by means of in
2512 person or telephone contact at the person's residence, for the
2513 purpose of making motor vehicle tort claims or claims for
2514 personal injury protection or emergency care coverage benefits
2515 required by s. 627.736 or 627.7485, as applicable. Any person
2516 who violates this paragraph commits a felony of the third
2517 degree, punishable as provided in s. 775.082, s. 775.083, or s.
2518 775.084.

2519 (9) A person may not organize, plan, or knowingly
2520 participate in an intentional motor vehicle crash or a scheme to
2521 create documentation of a motor vehicle crash that did not occur
2522 for the purpose of making motor vehicle tort claims or claims
2523 for personal injury protection or emergency care coverage
2524 benefits as required by s. 627.736 or s. 627.7485, as
2525 applicable. Any person who violates this subsection commits a
2526 felony of the second degree, punishable as provided in s.
2527 775.082, s. 775.083, or s. 775.084. A person who is convicted of
2528 a violation of this subsection shall be sentenced to a minimum
2529 term of imprisonment of 2 years.

2530 (10) A licensed health care practitioner who is found
2531 guilty of insurance fraud under this section for an act relating
2532 to a personal injury protection or emergency care coverage
2533 insurance policy may not be licensed or continue to be licensed
2534 for 5 years and may not receive reimbursement for benefits under
2535 such policies for 10 years. ~~As used in this section, the term~~



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2536 ~~"insurer" means any insurer, health maintenance organization,~~
2537 ~~self-insurer, self-insurance fund, or other similar entity or~~
2538 ~~person regulated under chapter 440 or chapter 641 or by the~~
2539 ~~Office of Insurance Regulation under the Florida Insurance Code.~~

2540 (13) As used in this section, the term:

2541 (a) "Insurer" means any insurer, health maintenance
2542 organization, self-insurer, self-insurance fund, or similar
2543 entity or person regulated under chapter 440 or chapter 641 or
2544 by the Office of Insurance Regulation under the Florida
2545 Insurance Code.

2546 (b) ~~(a)~~ "Property" means property as defined in s. 812.012.

2547 (c) ~~(b)~~ "Value" means value as defined in s. 812.012.

2548 Section 22. Subsection (4) of section 316.065, Florida
2549 Statutes, is amended to read:

2550 316.065 Crashes; reports; penalties.—

2551 (4) Any person who knowingly repairs a motor vehicle
2552 without having made a report as required by subsection (3) is
2553 guilty of a misdemeanor of the first degree, punishable as
2554 provided in s. 775.082 or s. 775.083. The owner and driver of a
2555 vehicle involved in a crash who makes a report thereof in
2556 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable
2557 under this section.

2558 Section 23. Subsection (1) of section 316.646, Florida
2559 Statutes, is amended to read:

2560 316.646 Security required; proof of security and display
2561 thereof; dismissal of cases.—

2562 (1) Any person required by s. 324.022 to maintain property
2563 damage liability security, required by s. 324.023 to maintain
2564 liability security for bodily injury or death, ~~or~~ required by s.



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2565 627.733 to maintain personal injury protection security, or
2566 required by s. 627.7483 to maintain emergency care coverage
2567 security, as applicable, on a motor vehicle must ~~shall~~ have in
2568 his or her immediate possession at all times while operating
2569 such motor vehicle proper proof of maintenance of the required
2570 security. Such proof must ~~shall~~ be a uniform proof-of-insurance
2571 card in a form prescribed by the department, a valid insurance
2572 policy, an insurance policy binder, a certificate of insurance,
2573 or such other proof as may be prescribed by the department.

2574 Section 24. Paragraph (b) of subsection (2) of section
2575 318.18, Florida Statutes, is amended to read:

2576 318.18 Amount of penalties.—The penalties required for a
2577 noncriminal disposition pursuant to s. 318.14 or a criminal
2578 offense listed in s. 318.17 are as follows:

2579 (2) Thirty dollars for all nonmoving traffic violations
2580 and:

2581 (b) For all violations of ss. 320.0605, 320.07(1), 322.065,
2582 and 322.15(1). Any person who is cited for a violation of s.
2583 320.07(1) shall be charged a delinquent fee pursuant to s.
2584 320.07(4).

2585 1. If a person who is cited for a violation of s. 320.0605
2586 or s. 320.07 can show proof of having a valid registration at
2587 the time of arrest, the clerk of the court may dismiss the case
2588 and may assess a dismissal fee of up to \$10. A person who finds
2589 it impossible or impractical to obtain a valid registration
2590 certificate must submit an affidavit detailing the reasons for
2591 the impossibility or impracticality. The reasons may include,
2592 but are not limited to, the fact that the vehicle was sold,
2593 stolen, or destroyed; that the state in which the vehicle is



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2594 registered does not issue a certificate of registration; or that
2595 the vehicle is owned by another person.

2596 2. If a person who is cited for a violation of s. 322.03,
2597 s. 322.065, or s. 322.15 can show a driver ~~driver's~~ license
2598 issued to him or her and valid at the time of arrest, the clerk
2599 of the court may dismiss the case and may assess a dismissal fee
2600 of up to \$10.

2601 3. If a person who is cited for a violation of s. 316.646
2602 can show proof of security as required by s. 627.733 or s.
2603 627.7483, as applicable, issued to the person and valid at the
2604 time of arrest, the clerk of the court may dismiss the case and
2605 may assess a dismissal fee of up to \$10. A person who finds it
2606 impossible or impractical to obtain proof of security must
2607 submit an affidavit detailing the reasons for the
2608 impracticality. The reasons may include, but are not limited to,
2609 the fact that the vehicle has since been sold, stolen, or
2610 destroyed; that the owner or registrant of the vehicle is not
2611 required by s. 627.733 or s. 627.7483 to maintain personal
2612 injury protection insurance or emergency care coverage
2613 insurance, as applicable; or that the vehicle is owned by
2614 another person.

2615 Section 25. Paragraphs (a) and (d) of subsection (5) of
2616 section 320.02, Florida Statutes, are amended to read:

2617 320.02 Registration required; application for registration;
2618 forms.-

2619 (5) (a) Proof that personal injury protection benefits or
2620 emergency care coverage benefits, as applicable, have been
2621 purchased if when required under s. 627.733 or s. 627.7483, as
2622 applicable, that property damage liability coverage has been



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2623 purchased as required under s. 324.022, that bodily injury or
2624 death coverage has been purchased if required under s. 324.023,
2625 and that combined bodily liability insurance and property damage
2626 liability insurance have been purchased if ~~when~~ required under
2627 s. 627.7415 shall be provided in the manner prescribed by law by
2628 the applicant at the time of application for registration of any
2629 motor vehicle that is subject to such requirements. The issuing
2630 agent shall refuse to issue registration if such proof of
2631 purchase is not provided. Insurers shall furnish uniform proof-
2632 of-purchase cards in a form prescribed by the department and
2633 ~~shall~~ include the name of the insured's insurance company, the
2634 coverage identification number, and the make, year, and vehicle
2635 identification number of the vehicle insured. The card must
2636 ~~shall~~ contain a statement notifying the applicant of the penalty
2637 specified in s. 316.646(4). The card or insurance policy,
2638 insurance policy binder, or certificate of insurance or a
2639 photocopy of any of these; an affidavit containing the name of
2640 the insured's insurance company, the insured's policy number,
2641 and the make and year of the vehicle insured; or such other
2642 proof as may be prescribed by the department ~~shall~~ constitute
2643 sufficient proof of purchase. If an affidavit is provided as
2644 proof, it must ~~shall~~ be in substantially the following form:

2645
2646 Under penalty of perjury, I ...(Name of insured)... do
2647 hereby certify that I have ...(Personal Injury Protection or
2648 Emergency Care Coverage, as applicable, Property Damage
2649 Liability, and, if ~~when~~ required, Bodily Injury Liability)...
2650 Insurance currently in effect with ...(Name of insurance
2651 company)... under ...(policy number)... covering ...(make, year,



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2652 and vehicle identification number of vehicle).... ..(Signature
2653 of Insured)...

2654

2655 The ~~Such~~ affidavit must ~~shall~~ include the following
2656 warning:

2657

2658 WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A
2659 VEHICLE REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER
2660 FLORIDA LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT
2661 IS SUBJECT TO PROSECUTION.

2662

2663 If ~~When~~ an application is made through a licensed motor
2664 vehicle dealer as required in s. 319.23, the original or a
2665 photostatic copy of such card, insurance policy, insurance
2666 policy binder, or certificate of insurance or the original
2667 affidavit from the insured shall be forwarded by the dealer to
2668 the tax collector of the county or the Department of Highway
2669 Safety and Motor Vehicles for processing. By executing the
2670 aforesaid affidavit, the ~~no~~ licensed motor vehicle dealer will
2671 not be liable in damages for any inadequacy, insufficiency, or
2672 falsification of any statement contained therein. A card must
2673 ~~shall~~ also indicate the existence of any bodily injury liability
2674 insurance voluntarily purchased.

2675

2676 (d) The verifying of proof of personal injury protection
2677 insurance or emergency care coverage insurance, as applicable,
2678 proof of property damage liability insurance, proof of combined
2679 bodily liability insurance and property damage liability
2680 insurance, or proof of financial responsibility insurance and
the issuance or failure to issue the motor vehicle registration



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2681 under ~~the provisions of~~ this chapter may not be construed in any
2682 court as a warranty of the reliability or accuracy of the
2683 evidence of such proof. Neither the department nor any tax
2684 collector is liable in damages for any inadequacy,
2685 insufficiency, falsification, or unauthorized modification of
2686 any item of the proof of personal injury protection insurance or
2687 emergency care coverage insurance, as applicable, proof of
2688 property damage liability insurance, proof of combined bodily
2689 liability insurance and property damage liability insurance, or
2690 proof of financial responsibility insurance before ~~prior to,~~
2691 during, or subsequent to the verification of the proof. The
2692 issuance of a motor vehicle registration does not constitute
2693 prima facie evidence or a presumption of insurance coverage.

2694 Section 26. Paragraph (b) of subsection (1) of section
2695 320.0609, Florida Statutes, is amended to read:

2696 320.0609 Transfer and exchange of registration license
2697 plates; transfer fee.—

2698 (1)

2699 (b) The transfer of a license plate from a vehicle disposed
2700 of to a newly acquired vehicle does not constitute a new
2701 registration. The application for transfer shall be accepted
2702 without requiring proof of personal injury protection insurance
2703 or emergency care coverage insurance, as applicable, or
2704 liability insurance.

2705 Section 27. Subsection (3) of section 320.27, Florida
2706 Statutes, is amended to read:

2707 320.27 Motor vehicle dealers.—

2708 (3) APPLICATION AND FEE.—The application for the license
2709 must ~~shall~~ be in such form as may be prescribed by the



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2710 department and ~~shall be~~ subject to such rules with respect
2711 thereto as may be so prescribed by it. Such application must
2712 ~~shall~~ be verified by oath or affirmation and ~~shall~~ contain a
2713 full statement of the name and birth date of the applicant
2714 ~~person or persons applying therefor~~; the name of the firm or
2715 copartnership, with the names and places of residence of all
2716 members thereof, if such applicant is a firm or copartnership;
2717 the names and places of residence of the principal officers, if
2718 the applicant is a body corporate or other artificial body; the
2719 name of the state under whose laws the corporation is organized;
2720 the present and former place or places of residence of the
2721 applicant; and prior business in which the applicant has been
2722 engaged and the location thereof. The ~~Such~~ application must
2723 ~~shall~~ describe the exact location of the place of business and
2724 ~~shall~~ state whether the place of business is owned by the
2725 applicant and if ~~when~~ acquired, or, if leased, a true copy of
2726 the lease must ~~shall~~ be attached to the application. The
2727 applicant shall certify that the location provides an adequately
2728 equipped office and is not a residence; that the location
2729 affords sufficient unoccupied space upon and within which to
2730 adequately ~~to~~ store all motor vehicles offered and displayed for
2731 sale; and that the location is a suitable place where the
2732 applicant can in good faith carry on such business and keep and
2733 maintain books, records, and files necessary to conduct such
2734 business, which will be available at all reasonable hours for ~~to~~
2735 inspection by the department or ~~any of~~ its inspectors or other
2736 employees. The applicant shall certify that the business of a
2737 motor vehicle dealer is the principal business that will ~~which~~
2738 ~~shall~~ be conducted at that location. The ~~Such~~ application must



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2739 ~~shall~~ contain a statement that the applicant is ~~either~~
2740 franchised by a manufacturer of motor vehicles, in which case
2741 the name of each motor vehicle that the applicant is franchised
2742 to sell shall be included, or an independent, ~~(nonfranchised,)~~
2743 motor vehicle dealer. The ~~Such~~ application must ~~shall~~ contain
2744 such other relevant information as may be required by the
2745 department, including evidence that the applicant is insured
2746 under a garage liability insurance policy or a general liability
2747 insurance policy coupled with a business automobile policy,
2748 which includes ~~shall include~~, at a minimum, \$25,000 combined
2749 single-limit liability coverage including bodily injury and
2750 property damage protection and \$10,000 personal injury
2751 protection or emergency care coverage, as applicable. Franchise
2752 dealers must submit a garage liability insurance policy, and all
2753 other dealers must submit a garage liability insurance policy or
2754 a general liability insurance policy coupled with a business
2755 automobile policy. The ~~Such~~ policy shall be for the license
2756 period, and evidence of a new or continued policy must ~~shall~~ be
2757 delivered to the department at the beginning of each license
2758 period. Upon making initial application, the applicant shall pay
2759 to the department a fee of \$300 in addition to any other fees
2760 ~~now~~ required by law; upon making a subsequent renewal
2761 application, the applicant shall pay to the department a fee of
2762 \$75 in addition to any other fees ~~now~~ required by law. Upon
2763 making an application for a change of location, the person shall
2764 pay a fee of \$50 in addition to any other fees ~~now~~ required by
2765 law. The department shall, in the case of every application for
2766 initial licensure, verify whether certain facts set forth in the
2767 application are true. Each applicant, general partner in the



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2768 case of a partnership, or corporate officer and director in the
2769 case of a corporate applicant, must file a set of fingerprints
2770 with the department for the purpose of determining any prior
2771 criminal record or any outstanding warrants. The department
2772 shall submit the fingerprints to the Department of Law
2773 Enforcement for state processing and forwarding to the Federal
2774 Bureau of Investigation for federal processing. The actual cost
2775 of state and federal processing shall be borne by the applicant
2776 and is in addition to the fee for licensure. The department may
2777 issue a license to an applicant pending the results of the
2778 fingerprint investigation, which ~~license~~ is fully revocable if
2779 the department subsequently determines that any facts set forth
2780 in the application are not true or correctly represented.

2781 Section 28. Paragraph (j) of subsection (3) of section
2782 320.771, Florida Statutes, is amended to read:

2783 320.771 License required of recreational vehicle dealers.—

2784 (3) APPLICATION.—The application for such license shall be
2785 in the form prescribed by the department and subject to such
2786 rules as may be prescribed by it. The application shall be
2787 verified by oath or affirmation and shall contain:

2788 (j) A statement that the applicant is insured under a
2789 garage liability insurance policy, which ~~shall include~~, at a
2790 minimum, includes \$25,000 combined single-limit liability
2791 coverage, including bodily injury and property damage
2792 protection, and \$10,000 personal injury protection or emergency
2793 care coverage, as applicable, if the applicant is to be licensed
2794 as a dealer in, or intends to sell, recreational vehicles.

2795
2796 The department shall, if it deems necessary, cause an



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2797 investigation to be made to ascertain if the facts set forth in
2798 the application are true and may ~~shall~~ not issue a license to
2799 the applicant until it is satisfied that the facts set forth in
2800 the application are true.

2801 Section 29. Subsection (1) of section 322.251, Florida
2802 Statutes, is amended to read:

2803 322.251 Notice of cancellation, suspension, revocation, or
2804 disqualification of license.—

2805 (1) All orders of cancellation, suspension, revocation, or
2806 disqualification issued under ~~the provisions of~~ this chapter,
2807 chapter 318, chapter 324, ~~or~~ ss. 627.732-627.734, or ss.
2808 627.748-627.7491 must be made ~~shall be given either~~ by personal
2809 delivery ~~thereof~~ to the licensee whose license is being
2810 canceled, suspended, revoked, or disqualified or by deposit in
2811 the United States mail in an envelope, first class, postage
2812 prepaid, addressed to the licensee at his or her last known
2813 mailing address furnished to the department. Such mailing by the
2814 department constitutes notification, and any failure by the
2815 person to receive the mailed order does ~~will~~ not affect or stay
2816 the effective date or term of the cancellation, suspension,
2817 revocation, or disqualification of the licensee's driving
2818 privilege.

2819 Section 30. Paragraph (a) of subsection (8) of section
2820 322.34, Florida Statutes, is amended to read:

2821 322.34 Driving while license suspended, revoked, canceled,
2822 or disqualified.—

2823 (8) (a) Upon the arrest of a person for the offense of
2824 driving while the person's driver ~~driver's~~ license or driving
2825 privilege is suspended or revoked, the arresting officer must



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2826 ~~shall~~ determine:

2827 1. Whether the person's driver ~~driver's~~ license is
2828 suspended or revoked.

2829 2. Whether the person's driver ~~driver's~~ license has
2830 remained suspended or revoked since a conviction for the offense
2831 of driving with a suspended or revoked license.

2832 3. Whether the suspension or revocation was made under s.
2833 316.646, ~~or~~ s. 627.733, or s. 627.7483, relating to failure to
2834 maintain required security, or under s. 322.264, relating to
2835 habitual traffic offenders.

2836 4. Whether the driver is the registered owner or coowner of
2837 the vehicle.

2838 Section 31. Subsection (1) and paragraph (c) of subsection
2839 (9) of section 324.021, Florida Statutes, are amended to read:

2840 324.021 Definitions; minimum insurance required.—The
2841 following words and phrases when used in this chapter shall, for
2842 the purpose of this chapter, have the meanings respectively
2843 ascribed to them in this section, except in those instances
2844 where the context clearly indicates a different meaning:

2845 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
2846 is designed and required to be licensed for use upon a highway,
2847 including trailers and semitrailers designed for use with such
2848 vehicles, except traction engines, road rollers, farm tractors,
2849 power shovels, and well drillers, and every vehicle that ~~which~~
2850 is propelled by electric power obtained from overhead wires but
2851 not operated upon rails, but not including any bicycle or moped.
2852 However, the term "motor vehicle" does ~~shall~~ not include a any
2853 motor vehicle as defined in s. 627.732(3) or s. 627.7482(9), as
2854 applicable, if ~~when~~ the owner of such vehicle has complied with



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2855 ~~the requirements of ss. 627.730-627.7405 or ss. 627.748-~~
2856 ~~627.7491, as applicable, inclusive, unless the provisions of s.~~
2857 ~~324.051 applies apply;~~ and, in such case, the applicable proof
2858 of insurance provisions of s. 320.02 apply.

2859 (9) OWNER; OWNER/LESSOR.-

2860 (c) *Application*.-

2861 1. The limits on liability in subparagraphs (b)2. and 3. do
2862 not apply to an owner of motor vehicles that are used for
2863 commercial activity in the owner's ordinary course of business,
2864 other than a rental company that rents or leases motor vehicles.
2865 For purposes of this paragraph, the term "rental company"
2866 includes only an entity that is engaged in the business of
2867 renting or leasing motor vehicles to the general public and that
2868 rents or leases a majority of its motor vehicles to persons who
2869 have ~~with~~ no direct or indirect affiliation with the rental
2870 company. The term also includes a motor vehicle dealer that
2871 provides temporary replacement vehicles to its customers for up
2872 to 10 days. The term "rental company" also includes:

2873 a. A related rental or leasing company that is a subsidiary
2874 of the same parent company as that of the renting or leasing
2875 company that rented or leased the vehicle.

2876 b. The holder of a motor vehicle title or an equity
2877 interest in a motor vehicle title if the title or equity
2878 interest is held pursuant to or to facilitate an asset-backed
2879 securitization of a fleet of motor vehicles used solely in the
2880 business of renting or leasing motor vehicles to the general
2881 public and under the dominion and control of a rental company,
2882 as described in this subparagraph, in the operation of such
2883 rental company's business.



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2884 2. ~~Furthermore,~~ With respect to commercial motor vehicles
2885 as defined in s. 627.732 or s. 627.7482, as applicable, the
2886 limits on liability in subparagraphs (b)2. and 3. do not apply
2887 if, at the time of the incident, the commercial motor vehicle is
2888 being used in the transportation of materials found to be
2889 hazardous for the purposes of the Hazardous Materials
2890 Transportation Authorization Act of 1994, as amended, 49 U.S.C.
2891 ss. 5101 et seq., and that is required pursuant to such act to
2892 carry placards warning others of the hazardous cargo, unless at
2893 the time of lease or rental ~~either:~~

2894 a. The lessee indicates in writing that the vehicle will
2895 not be used to transport materials found to be hazardous for the
2896 purposes of the Hazardous Materials Transportation Authorization
2897 Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq.; or

2898 b. The lessee or other operator of the commercial motor
2899 vehicle has in effect insurance with limits of at least
2900 \$5,000,000 combined property damage and bodily injury liability.

2901 Section 32. Section 324.0221, Florida Statutes, is amended
2902 to read:

2903 324.0221 Reports by insurers to the department; suspension
2904 of driver ~~driver's~~ license and vehicle registrations;
2905 reinstatement.—

2906 (1) (a) Each insurer that has issued a policy providing
2907 personal injury protection or emergency care coverage or
2908 property damage liability coverage shall report the renewal,
2909 cancellation, or nonrenewal of the policy ~~thereof~~ to the
2910 department within 45 days after the effective date of each
2911 renewal, cancellation, or nonrenewal. Upon the issuance of a
2912 policy providing personal injury protection or emergency care



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2913 coverage or property damage liability coverage to a named
2914 insured not previously insured by the insurer during that
2915 calendar year, the insurer shall report the issuance of the new
2916 policy to the department within 30 days. The report shall be in
2917 the form and format and contain any information required by the
2918 department and must be provided in a format that is compatible
2919 with the data processing capabilities of the department. The
2920 department may adopt rules regarding the form and documentation
2921 required. Failure by an insurer to file proper reports with the
2922 department as required by this subsection or rules adopted with
2923 respect to the requirements of this subsection constitutes a
2924 violation of the Florida Insurance Code. These records shall be
2925 used by the department only for enforcement and regulatory
2926 purposes, including the generation by the department of data
2927 regarding compliance by owners of motor vehicles with the
2928 requirements for financial responsibility coverage.

2929 (b) With respect to an insurance policy providing personal
2930 injury protection or emergency care coverage or property damage
2931 liability coverage, each insurer shall notify the named insured,
2932 or the first-named insured in the case of a commercial fleet
2933 policy, in writing that any cancellation or nonrenewal of the
2934 policy will be reported by the insurer to the department. The
2935 notice must also inform the named insured that failure to
2936 maintain personal injury protection or emergency care coverage
2937 and property damage liability coverage on a motor vehicle as
2938 ~~when~~ required by law may result in the loss of registration and
2939 driving privileges in this state and inform the named insured of
2940 the amount of the reinstatement fees required by this section.
2941 This notice is for informational purposes only, and an insurer



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2942 is not civilly liable for failing to provide this notice.

2943 (2) The department shall suspend, after due notice and an
2944 opportunity to be heard, the registration and driver ~~driver's~~
2945 license of any owner or registrant of a motor vehicle with
2946 respect to which security is required under s. ss. 324.022 and
2947 either s. 627.733 or s. 627.7483, as applicable, upon:

2948 (a) The department's records showing that the owner or
2949 registrant of such motor vehicle did not have in full force and
2950 effect when required security that complies with the
2951 requirements of s. ss. 324.022 and either s. 627.733 or s.
2952 627.7483, as applicable; or

2953 (b) Notification by the insurer to the department, in a
2954 form approved by the department, of cancellation or termination
2955 of the required security.

2956 (3) An operator or owner whose driver ~~driver's~~ license or
2957 registration has been suspended under this section or s. 316.646
2958 may effect its reinstatement upon compliance with the
2959 requirements of this section and upon payment to the department
2960 of a nonrefundable reinstatement fee of \$150 for the first
2961 reinstatement. The reinstatement fee is \$250 for the second
2962 reinstatement and \$500 for each subsequent reinstatement during
2963 the 3 years following the first reinstatement. A person
2964 reinstating her or his insurance under this subsection must also
2965 secure noncancelable coverage as described in ss. 324.021(8),
2966 324.023, and 627.7275(2) and present proof to the appropriate
2967 person ~~proof~~ that the coverage is in force on a form adopted by
2968 the department, and such proof shall be maintained for 2 years.
2969 If the person does not have a second reinstatement within 3
2970 years after her or his initial reinstatement, the reinstatement



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2971 fee is \$150 for the first reinstatement after that 3-year
2972 period. If a person's license and registration are suspended
2973 under this section or s. 316.646, only one reinstatement fee
2974 must be paid to reinstate the license and the registration. All
2975 fees shall be collected by the department at the time of
2976 reinstatement. The department shall issue proper receipts for
2977 such fees and ~~shall~~ promptly deposit those fees in the Highway
2978 Safety Operating Trust Fund. One-third of the fees collected
2979 ~~under this subsection~~ shall be distributed from the Highway
2980 Safety Operating Trust Fund to the local governmental entity or
2981 state agency that employed the law enforcement officer seizing
2982 the license plate pursuant to s. 324.201. The funds may be used
2983 by the local governmental entity or state agency for any
2984 authorized purpose.

2985 Section 33. Paragraph (a) of subsection (1) of section
2986 324.032, Florida Statutes, is amended to read:

2987 324.032 Manner of proving financial responsibility; for-
2988 hire passenger transportation vehicles.—Notwithstanding the
2989 provisions of s. 324.031:

2990 (1) (a) A person who is ~~either~~ the owner or a lessee
2991 required to maintain insurance under s. 627.733(1) (b) or s.
2992 627.7483(1), as applicable, and who operates one or more
2993 taxicabs, limousines, jitneys, or any other for-hire passenger
2994 transportation vehicles may prove financial responsibility by
2995 furnishing satisfactory evidence of holding a motor vehicle
2996 liability policy that has, ~~but with~~ minimum limits of
2997 \$125,000/250,000/50,000.

2998
2999 Upon request by the department, the applicant must provide the



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3000 department at the applicant's principal place of business in
3001 this state access to the applicant's underlying financial
3002 information and financial statements that provide the basis of
3003 the certified public accountant's certification. The applicant
3004 shall reimburse the requesting department for all reasonable
3005 costs incurred by it in reviewing the supporting information.
3006 The maximum amount of self-insurance permissible under this
3007 subsection is \$300,000 and must be stated on a per-occurrence
3008 basis, and the applicant shall maintain adequate excess
3009 insurance issued by an authorized or eligible insurer licensed
3010 or approved by the Office of Insurance Regulation. All risks
3011 self-insured shall remain with the owner or lessee providing it,
3012 and the risks are not transferable to any other person, unless a
3013 policy complying with subsection (1) is obtained.

3014 Section 34. Subsection (2) of section 324.171, Florida
3015 Statutes, is amended to read:

3016 324.171 Self-insurer.—

3017 (2) The self-insurance certificate must ~~shall~~ provide
3018 limits of liability insurance in the amounts specified under s.
3019 324.021(7) or s. 627.7415 and ~~shall~~ provide personal injury
3020 protection or emergency care coverage under s. 627.733(3)(b) or
3021 s. 627.7483(3)(b), as applicable.

3022 Section 35. Paragraph (g) of subsection (1) of section
3023 400.9935, Florida Statutes, is amended to read:

3024 400.9935 Clinic responsibilities.—

3025 (1) Each clinic shall appoint a medical director or clinic
3026 director who shall agree in writing to accept legal
3027 responsibility for the following activities on behalf of the
3028 clinic. The medical director or the clinic director shall:



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3029 (g) Conduct systematic reviews of clinic billings to ensure
3030 that the billings are not fraudulent or unlawful. Upon discovery
3031 of an unlawful charge, the medical director or clinic director
3032 must ~~shall~~ take immediate corrective action. If the clinic
3033 performs only the technical component of magnetic resonance
3034 imaging, static radiographs, computed tomography, or positron
3035 emission tomography, and provides the professional
3036 interpretation of such services, in a fixed facility that is
3037 accredited by the Joint Commission on Accreditation of
3038 Healthcare Organizations or the Accreditation Association for
3039 Ambulatory Health Care, and the American College of Radiology;
3040 and if, in the preceding quarter, the percentage of scans
3041 performed by that clinic which was billed to all personal injury
3042 protection insurance or emergency care coverage insurance
3043 carriers was less than 15 percent, the chief financial officer
3044 of the clinic may, in a written acknowledgment provided to the
3045 agency, assume ~~the~~ responsibility for the conduct of the
3046 systematic reviews of clinic billings to ensure that the
3047 billings are not fraudulent or unlawful.

3048 Section 36. Subsection (28) of section 409.901, Florida
3049 Statutes, is amended to read:

3050 409.901 Definitions; ss. 409.901-409.920.—As used in ss.
3051 409.901-409.920, except as otherwise specifically provided, the
3052 term:

3053 (28) "Third-party benefit" means any benefit that is or may
3054 be available at any time through contract, court award,
3055 judgment, settlement, agreement, or any arrangement between a
3056 third party and any person or entity, including, without
3057 limitation, a Medicaid recipient, a provider, another third



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3058 party, an insurer, or the agency, for any Medicaid-covered
3059 injury, illness, goods, or services, including costs of related
3060 medical services ~~related thereto~~, for personal injury or for
3061 death of the recipient, but specifically excluding policies of
3062 life insurance on the recipient, unless available under terms of
3063 the policy to pay medical expenses before ~~prior to~~ death. The
3064 term includes, without limitation, collateral, ~~as defined in~~
3065 ~~this section~~, health insurance, any benefit under a health
3066 maintenance organization, a preferred provider arrangement, a
3067 prepaid health clinic, liability insurance, uninsured motorist
3068 insurance or personal injury protection or emergency care
3069 coverage, medical benefits under workers' compensation, and any
3070 obligation under law or equity to provide medical support.

3071 Section 37. Paragraph (f) of subsection (11) of section
3072 409.910, Florida Statutes, is amended to read:

3073 409.910 Responsibility for payments on behalf of Medicaid-
3074 eligible persons when other parties are liable.-

3075 (11) The agency may, as a matter of right, in order to
3076 enforce its rights under this section, institute, intervene in,
3077 or join any legal or administrative proceeding in its own name
3078 in one or more of the following capacities: individually, as
3079 subrogee of the recipient, as assignee of the recipient, or as
3080 lienholder of the collateral.

3081 (f) Notwithstanding any other provision in this section ~~to~~
3082 ~~the contrary~~, in the event of an action in tort against a third
3083 party in which the recipient or his or her legal representative
3084 is a party which results in a judgment, award, or settlement
3085 from a third party, the amount recovered shall be distributed as
3086 follows:



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3087 1. After attorney ~~attorney's~~ fees and taxable costs as
3088 defined by the Florida Rules of Civil Procedure, one-half of the
3089 remaining recovery shall be paid to the agency up to the total
3090 amount of medical assistance provided by Medicaid.

3091 2. The remaining amount of the recovery shall be paid to
3092 the recipient.

3093 3. For purposes of calculating the agency's recovery of
3094 medical assistance benefits paid, the fee for services of an
3095 attorney retained by the recipient or his or her legal
3096 representative shall be calculated at 25 percent of the
3097 judgment, award, or settlement.

3098 4. Notwithstanding any other provision of this section ~~to~~
3099 ~~the contrary~~, the agency is ~~shall be~~ entitled to all medical
3100 coverage benefits up to the total amount of medical assistance
3101 provided by Medicaid. For purposes of this paragraph, "medical
3102 coverage" means any benefits under health insurance, a health
3103 maintenance organization, a preferred provider arrangement, or a
3104 prepaid health clinic, and the portion of benefits designated
3105 for medical payments under coverage for workers' compensation,
3106 emergency care coverage, personal injury protection, and
3107 casualty.

3108 Section 38. Paragraph (k) of subsection (2) of section
3109 456.057, Florida Statutes, is amended to read:

3110 456.057 Ownership and control of patient records; report or
3111 copies of records to be furnished.—

3112 (2) As used in this section, the terms "records owner,"
3113 "health care practitioner," and "health care practitioner's
3114 employer" do not include any of the following persons or
3115 entities; furthermore, the following persons or entities may ~~are~~



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3116 not ~~authorized to~~ acquire or own medical records, but, are
3117 ~~authorized~~ under the confidentiality and disclosure requirements
3118 of this section, may ~~to~~ maintain those documents that are
3119 required by the part or chapter under which they are licensed or
3120 regulated:

3121 (k) Persons or entities practicing under s. 627.736(7) or
3122 s. 627.7485(7), as applicable.

3123 Section 39. Paragraphs (ee) and (ff) of subsection (1) of
3124 section 456.072, Florida Statutes, are amended to read:

3125 456.072 Grounds for discipline; penalties; enforcement.—

3126 (1) The following acts shall constitute grounds for which
3127 the disciplinary actions specified in subsection (2) may be
3128 taken:

3129 (ee) With respect to making a personal injury protection or
3130 an emergency care coverage claim as required by s. 627.736 or s.
3131 627.7485, respectively, intentionally submitting a claim,
3132 statement, or bill that has been "upcoded" as defined in s.
3133 627.732 or s. 627.7482, as applicable.

3134 (ff) With respect to making a personal injury protection or
3135 an emergency care coverage claim as required by s. 627.736 or s.
3136 627.7485, respectively, intentionally submitting a claim,
3137 statement, or bill for payment of services that were not
3138 rendered.

3139 Section 40. Paragraph (o) of subsection (1) of section
3140 626.9541, Florida Statutes, is amended to read:

3141 626.9541 Unfair methods of competition and unfair or
3142 deceptive acts or practices defined.—

3143 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
3144 ACTS.—The following are defined as unfair methods of competition



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3145 and unfair or deceptive acts or practices:

3146 (o) *Illegal dealings in premiums; excess or reduced charges*
3147 *for insurance.*—

3148 1. Knowingly collecting any sum as a premium or charge for
3149 insurance, which is not then provided, or is not in due course
3150 to be provided, subject to acceptance of the risk by the
3151 insurer, by an insurance policy issued by an insurer as
3152 permitted by this code.

3153 2. Knowingly collecting as a premium or charge for
3154 insurance any sum in excess of or less than the premium or
3155 charge applicable to such insurance, in accordance with the
3156 applicable classifications and rates as filed with and approved
3157 by the office, and as specified in the policy; or, if in cases
3158 ~~when~~ classifications, premiums, or rates are not required by
3159 this code to be so filed and approved, premiums and charges
3160 collected from a Florida resident in excess of or less than
3161 those specified in the policy and as fixed by the insurer. This
3162 provision may ~~shall~~ not be deemed to prohibit the charging and
3163 collection, by surplus lines agents licensed under part VIII of
3164 this chapter, of the amount of applicable state and federal
3165 taxes, or fees as authorized by s. 626.916(4), in addition to
3166 the premium required by the insurer or the charging and
3167 collection, by licensed agents, of the exact amount of any
3168 discount or other such fee charged by a credit card facility in
3169 connection with the use of a credit card, as authorized by
3170 subparagraph (q)3., in addition to the premium required by the
3171 insurer. This subparagraph does ~~shall~~ not be construed to
3172 prohibit collection of a premium for a universal life or a
3173 variable or indeterminate value insurance policy made in



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3174 accordance with the terms of the contract.

3175 ~~3.a.~~ Imposing or requesting an additional premium for a
3176 policy of motor vehicle liability, emergency care coverage,
3177 personal injury protection, medical payment, or collision
3178 insurance or any combination thereof or refusing to renew the
3179 policy solely because the insured was involved in a motor
3180 vehicle accident unless the insurer's file contains information
3181 from which the insurer in good faith determines that the insured
3182 was substantially at fault in the accident.

3183 ~~a.b.~~ An insurer which imposes and collects such a surcharge
3184 or which refuses to renew such policy shall, in conjunction with
3185 the notice of premium due or notice of nonrenewal, notify the
3186 named insured that he or she is entitled to reimbursement of
3187 such amount or renewal of the policy under the conditions listed
3188 below and will subsequently reimburse him or her or renew the
3189 policy, if the named insured demonstrates that the operator
3190 involved in the accident was:

3191 (I) Lawfully parked;

3192 (II) Reimbursed by, or on behalf of, a person responsible
3193 for the accident or has a judgment against such person;

3194 (III) Struck in the rear by another vehicle headed in the
3195 same direction and was not convicted of a moving traffic
3196 violation in connection with the accident;

3197 (IV) Hit by a "hit-and-run" driver, if the accident was
3198 reported to the proper authorities within 24 hours after
3199 discovering the accident;

3200 (V) Not convicted of a moving traffic violation in
3201 connection with the accident, but the operator of the other
3202 automobile involved in such accident was convicted of a moving



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3203 traffic violation;

3204 (VI) Finally adjudicated not to be liable by a court of
3205 competent jurisdiction;

3206 (VII) In receipt of a traffic citation that ~~which~~ was
3207 dismissed or nolle prossed; or

3208 (VIII) Not at fault as evidenced by a written statement
3209 from the insured establishing facts demonstrating lack of fault
3210 which are not rebutted by information in the insurer's file from
3211 which the insurer in good faith determines that the insured was
3212 substantially at fault.

3213 ~~b.e.~~ In addition to the other provisions of this
3214 subparagraph, an insurer may not fail to renew a policy if the
3215 insured has had only one accident in which he or she was at
3216 fault within the current 3-year period. However, an insurer may
3217 nonrenew a policy for reasons other than accidents in accordance
3218 with s. 627.728. This subparagraph does not prohibit nonrenewal
3219 of a policy under which the insured has had three or more
3220 accidents, regardless of fault, during the most recent 3-year
3221 period.

3222 4. Imposing or requesting an additional premium for, or
3223 refusing to renew, a policy for motor vehicle insurance solely
3224 because the insured committed a noncriminal traffic infraction
3225 as described in s. 318.14 unless the infraction is:

3226 a. A second infraction committed within an 18-month period,
3227 or a third or subsequent infraction committed within a 36-month
3228 period.

3229 b. A violation of s. 316.183, if ~~when~~ such violation is a
3230 result of exceeding the lawful speed limit by more than 15 miles
3231 per hour.



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3232 5. Upon the request of the insured, the insurer and
3233 licensed agent shall supply to the insured the complete proof of
3234 fault or other criteria which justifies the additional charge or
3235 cancellation.

3236 6. Imposing or requesting ~~No insurer shall impose or~~
3237 ~~request~~ an additional premium for motor vehicle insurance,
3238 cancelling or refusing ~~cancel or refuse~~ to issue a policy, or
3239 refusing ~~refuse~~ to renew a policy because the insured or the
3240 applicant is a handicapped or physically disabled person if, so
3241 ~~long as~~ such handicap or physical disability does not
3242 substantially impair such person's mechanically assisted driving
3243 ability.

3244 7. Cancelling ~~No insurer may cancel~~ or otherwise
3245 terminating an ~~terminate any~~ insurance contract or coverage, or
3246 requiring ~~require~~ execution of a consent to rate endorsement,
3247 during the stated policy term for the purpose of offering to
3248 issue, or issuing, a similar or identical contract or coverage
3249 to the same insured with the same exposure at a higher premium
3250 rate or continuing an existing contract or coverage with the
3251 same exposure at an increased premium.

3252 8. Issuing ~~No insurer may issue~~ a nonrenewal notice on any
3253 insurance contract or coverage, or requiring ~~require~~ execution
3254 of a consent to rate endorsement, for the purpose of offering to
3255 issue, or issuing, a similar or identical contract or coverage
3256 to the same insured at a higher premium rate or continuing an
3257 existing contract or coverage at an increased premium without
3258 meeting any applicable notice requirements.

3259 9. ~~No insurer shall,~~ With respect to premiums charged for
3260 motor vehicle insurance, unfairly discriminating ~~discriminate~~



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3261 solely on the basis of age, sex, marital status, or scholastic
3262 achievement.

3263 10. Imposing or requesting an additional premium for motor
3264 vehicle comprehensive or uninsured motorist coverage solely
3265 because the insured was involved in a motor vehicle accident or
3266 was convicted of a moving traffic violation.

3267 11. Cancelling or issuing ~~No insurer shall cancel or issue~~
3268 a nonrenewal notice on any insurance policy or contract without
3269 complying with any applicable cancellation or nonrenewal
3270 provision required under the Florida Insurance Code.

3271 12. Imposing or requesting ~~No insurer shall impose or~~
3272 ~~request~~ an additional premium, cancelling ~~cancel~~ a policy, or
3273 issuing ~~issue~~ a nonrenewal notice on any insurance policy or
3274 contract because of any traffic infraction when adjudication has
3275 been withheld and no points have been assessed pursuant to s.
3276 318.14(9) and (10). However, this subparagraph does not apply to
3277 traffic infractions involving accidents in which the insurer has
3278 incurred a loss due to the fault of the insured.

3279 Section 41. Subsection (5) of section 626.9894, Florida
3280 Statutes, is amended to read:

3281 626.9894 Gifts and grants.—

3282 (5) Notwithstanding ~~the provisions of~~ s. 216.301 and
3283 pursuant to s. 216.351, any balance of moneys deposited into the
3284 Insurance Regulatory Trust Fund pursuant to this section or s.
3285 626.9895 remaining at the end of any fiscal year is ~~shall be~~
3286 available for carrying out the duties and responsibilities of
3287 the division. The department may request annual appropriations
3288 from the grants and donations received pursuant to this section
3289 or s. 626.9895 and cash balances in the Insurance Regulatory



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3290 Trust Fund for the purpose of carrying out its duties and
3291 responsibilities related to the division's anti-fraud efforts,
3292 including the funding of dedicated prosecutors and related
3293 personnel.

3294 Section 42. Subsection (1) of section 627.06501, Florida
3295 Statutes, is amended to read:

3296 627.06501 Insurance discounts for certain persons
3297 completing driver improvement course.—

3298 (1) Any rate, rating schedule, or rating manual for the
3299 liability, emergency care coverage, personal injury protection,
3300 and collision coverages of a motor vehicle insurance policy
3301 filed with the office may provide for an appropriate reduction
3302 in premium charges as to such coverages if ~~when~~ the principal
3303 operator on the covered vehicle has successfully completed a
3304 driver improvement course approved and certified by the
3305 Department of Highway Safety and Motor Vehicles which is
3306 effective in reducing crash or violation rates, or both, as
3307 determined pursuant to s. 318.1451(5). Any discount, not to
3308 exceed 10 percent, used by an insurer is presumed to be
3309 appropriate unless credible data demonstrates otherwise.

3310 Section 43. Subsection (1) of section 627.0652, Florida
3311 Statutes, is amended to read:

3312 627.0652 Insurance discounts for certain persons completing
3313 safety course.—

3314 (1) Any rates, rating schedules, or rating manuals for the
3315 liability, emergency care coverage, personal injury protection,
3316 and collision coverages of a motor vehicle insurance policy
3317 filed with the office must ~~shall~~ provide for an appropriate
3318 reduction in premium charges as to such coverages if ~~when~~ the



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3319 principal operator on the covered vehicle is an insured 55 years
3320 of age or older who has successfully completed a motor vehicle
3321 accident prevention course approved by the Department of Highway
3322 Safety and Motor Vehicles. Any discount used by an insurer is
3323 presumed to be appropriate unless credible data demonstrates
3324 otherwise.

3325 Section 44. Subsections (1) and (3) of section 627.0653,
3326 Florida Statutes, are amended to read:

3327 627.0653 Insurance discounts for specified motor vehicle
3328 equipment.—

3329 (1) Any rates, rating schedules, or rating manuals for the
3330 liability, emergency care coverage, personal injury protection,
3331 and collision coverages of a motor vehicle insurance policy
3332 filed with the office must ~~shall~~ provide a premium discount if
3333 the insured vehicle is equipped with factory-installed, four-
3334 wheel antilock brakes.

3335 (3) Any rates, rating schedules, or rating manuals for
3336 emergency care coverage, personal injury protection coverage,
3337 and medical payments coverage, if offered, of a motor vehicle
3338 insurance policy filed with the office shall provide a premium
3339 discount if the insured vehicle is equipped with one or more air
3340 bags that ~~which~~ are factory installed.

3341 Section 45. Section 627.4132, Florida Statutes, is amended
3342 to read:

3343 627.4132 Stacking of coverages prohibited.—If an insured or
3344 named insured is protected by any type of motor vehicle
3345 insurance policy for liability, emergency care coverage,
3346 personal injury protection, or other coverage, the policy must
3347 ~~shall~~ provide that the insured or named insured is protected



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3348 only to the extent of the coverage she or he has on the vehicle
3349 involved in the accident. However, if none of the insured's or
3350 named insured's vehicles is involved in the accident, coverage
3351 is available only to the extent of coverage on any one of the
3352 vehicles with applicable coverage. Coverage on any other
3353 vehicles may ~~shall~~ not be added to or stacked upon that
3354 coverage. This section does not apply:

3355 (1) To uninsured motorist coverage that ~~which~~ is separately
3356 governed by s. 627.727.

3357 (2) To reduce the coverage available by reason of insurance
3358 policies insuring different named insureds.

3359 Section 46. Subsection (6) of section 627.6482, Florida
3360 Statutes, is amended to read:

3361 627.6482 Definitions.—As used in ss. 627.648-627.6498, the
3362 term:

3363 (6) "Health insurance" means any hospital and medical
3364 expense incurred policy, minimum premium plan, stop-loss
3365 coverage, health maintenance organization contract, prepaid
3366 health clinic contract, multiple-employer welfare arrangement
3367 contract, or fraternal benefit society health benefits contract,
3368 whether sold as an individual or group policy or contract. The
3369 term does not include a ~~any~~ policy covering medical payment
3370 coverage or emergency care coverage or personal injury
3371 protection coverage in a motor vehicle policy, coverage issued
3372 as a supplement to liability insurance, or workers'
3373 compensation.

3374 Section 47. Section 627.7263, Florida Statutes, is amended
3375 to read:

3376 627.7263 Rental and leasing driver ~~driver's~~ insurance to be



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3377 primary; exception.—

3378 (1) The valid and collectible liability insurance,
3379 emergency care coverage insurance, or personal injury protection
3380 insurance providing coverage for the lessor of a motor vehicle
3381 for rent or lease is primary unless otherwise stated in at least
3382 10-point type on the face of the rental or lease agreement. Such
3383 insurance is primary for the limits of liability and personal
3384 injury protection or emergency care coverage as required by s.
3385 ~~ss.~~ 324.021(7) and either s. 627.736 or s. 627.7485, as
3386 applicable.

3387 (2) If the lessee's coverage is to be primary, the rental
3388 or lease agreement must contain the following language, in at
3389 least 10-point type:

3390
3391 "The valid and collectible liability insurance and
3392 personal injury protection insurance or emergency care
3393 coverage insurance, as applicable, of an any
3394 authorized rental or leasing driver is primary for the
3395 limits of liability and personal injury protection or
3396 emergency care coverage required by s. ~~ss.~~ 324.021(7)
3397 and either s. 627.736 or s. 627.7485, Florida
3398 Statutes, as applicable."

3399
3400 Section 48. Subsections (1) and (7) of section 627.727,
3401 Florida Statutes, are amended to read:

3402 627.727 Motor vehicle insurance; uninsured and underinsured
3403 vehicle coverage; insolvent insurer protection.—

3404 (1) A ~~No~~ motor vehicle liability insurance policy which
3405 provides bodily injury liability coverage may not shall be



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3406 delivered or issued for delivery in this state with respect to
3407 any specifically insured or identified motor vehicle registered
3408 or principally garaged in this state unless uninsured motor
3409 vehicle coverage is provided therein or supplemental thereto for
3410 the protection of persons insured thereunder who are legally
3411 entitled to recover damages from owners or operators of
3412 uninsured motor vehicles because of bodily injury, sickness, or
3413 disease, including death, resulting therefrom. However, the
3414 coverage required under this section is not applicable if when,
3415 or to the extent that, an insured named in the policy makes a
3416 written rejection of the coverage on behalf of all insureds
3417 under the policy. If when a motor vehicle is leased for a ~~period~~
3418 ~~of~~ 1 year or longer and the lessor ~~of such vehicle~~, by the terms
3419 of the lease contract, provides liability coverage on the leased
3420 vehicle, the lessee ~~of such vehicle~~ shall have the sole
3421 privilege to reject uninsured motorist coverage or to select
3422 lower limits than the bodily injury liability limits, regardless
3423 of whether the lessor is qualified as a self-insurer pursuant to
3424 s. 324.171. Unless an insured, or lessee having the privilege of
3425 rejecting uninsured motorist coverage, requests such coverage or
3426 requests higher uninsured motorist limits in writing, the
3427 coverage or such higher uninsured motorist limits need not be
3428 provided in or supplemental to any other policy that which
3429 renews, extends, changes, supersedes, or replaces an existing
3430 policy with the same bodily injury liability limits if when an
3431 insured or lessee had rejected the coverage. If when an insured
3432 or lessee has initially selected limits of uninsured motorist
3433 coverage lower than her or his bodily injury liability limits,
3434 higher limits of uninsured motorist coverage need not be



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3435 provided in or supplemental to any other policy that ~~which~~
3436 renews, extends, changes, supersedes, or replaces an existing
3437 policy with the same bodily injury liability limits unless an
3438 insured requests higher uninsured motorist coverage in writing.
3439 The rejection or selection of lower limits shall be made on a
3440 form approved by the office. The form must ~~shall~~ fully advise
3441 the applicant of the nature of the coverage and ~~shall~~ state that
3442 the coverage is equal to bodily injury liability limits unless
3443 lower limits are requested or the coverage is rejected. The
3444 heading of the form must ~~shall~~ be in 12-point bold type and
3445 ~~shall~~ state: "You are electing not to purchase certain valuable
3446 coverage that ~~which~~ protects you and your family or you are
3447 purchasing uninsured motorist limits less than your bodily
3448 injury liability limits when you sign this form. Please read
3449 carefully." If this form is signed by a named insured, it will
3450 be conclusively presumed that there was an informed, knowing
3451 rejection of coverage or election of lower limits on behalf of
3452 all insureds. The insurer shall notify the named insured at
3453 least annually of her or his options as to the coverage required
3454 by this section. Such notice must ~~shall~~ be part of, and attached
3455 to, the notice of premium, ~~shall~~ provide for a means to allow
3456 the insured to request such coverage, and ~~shall~~ be given in a
3457 manner approved by the office. Receipt of this notice does not
3458 constitute an affirmative waiver of the insured's right to
3459 uninsured motorist coverage if ~~where~~ the insured has not signed
3460 a selection or rejection form. The coverage described under this
3461 section shall be over and above, but may ~~shall~~ not duplicate,
3462 the benefits available to an insured under any workers'
3463 compensation law, emergency care coverage or personal injury



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3464 protection benefits, disability benefits law, or similar law;
3465 under any automobile medical expense coverage; under any motor
3466 vehicle liability insurance coverage; or from the owner or
3467 operator of the uninsured motor vehicle or any other person or
3468 organization jointly or severally liable together with such
3469 owner or operator for the accident; and such coverage must ~~shall~~
3470 cover the difference, if any, between the sum of such benefits
3471 and the damages sustained, up to the maximum amount of ~~such~~
3472 coverage provided under this section. The amount of coverage
3473 available under this section may ~~shall~~ not be reduced by a
3474 setoff against any coverage, including liability insurance. Such
3475 coverage may ~~shall~~ not inure directly or indirectly to the
3476 benefit of any workers' compensation or disability benefits
3477 carrier or any person or organization qualifying as a self-
3478 insurer under any workers' compensation or disability benefits
3479 law or similar law.

3480 (7) The legal liability of an uninsured motorist coverage
3481 insurer does not include damages in tort for pain, suffering,
3482 mental anguish, and inconvenience unless the injury or disease
3483 is described in one or more of paragraphs (a)-(d) of s.
3484 627.737(2) or paragraphs (a)-(d) of s. 627.7486(2).

3485 Section 49. Subsection (1) of section 627.7275, Florida
3486 Statutes, is amended to read:

3487 627.7275 Motor vehicle liability.—

3488 (1) A motor vehicle insurance policy providing personal
3489 injury protection as set forth in s. 627.736 or emergency care
3490 coverage as set forth in s. 627.7485 may not be delivered or
3491 issued for delivery in this state with respect to any
3492 specifically insured or identified motor vehicle registered or



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3493 principally garaged in this state unless the policy also
3494 provides coverage for property damage liability as required by
3495 s. 324.022.

3496 Section 50. Paragraph (a) of subsection (1) of section
3497 627.728, Florida Statutes, is amended to read:

3498 627.728 Cancellations; nonrenewals.—

3499 (1) As used in this section, the term:

3500 (a) "Policy" means the bodily injury and property damage
3501 liability, emergency care coverage, personal injury protection,
3502 medical payments, comprehensive, collision, and uninsured
3503 motorist coverage portions of a policy of motor vehicle
3504 insurance delivered or issued for delivery in this state:

3505 1. Insuring a natural person as named insured or one or
3506 more related individuals resident of the same household; and

3507 2. Insuring only a motor vehicle of the private passenger
3508 type or station wagon type which is not used as a public or
3509 livery conveyance for passengers or rented to others; or
3510 insuring any other four-wheel motor vehicle having a load
3511 capacity of 1,500 pounds or less which is not used in the
3512 occupation, profession, or business of the insured other than
3513 farming; other than any policy issued under an automobile
3514 insurance assigned risk plan; insuring more than four
3515 automobiles; or covering garage, automobile sales agency, repair
3516 shop, service station, or public parking place operation
3517 hazards.

3518
3519 The term "policy" does not include a binder as defined in s.
3520 627.420 unless the duration of the binder period exceeds 60
3521 days.



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3522 Section 51. Subsection (1), paragraph (a) of subsection
3523 (5), and subsections (6) and (7) of section 627.7295, Florida
3524 Statutes, are amended to read:

3525 627.7295 Motor vehicle insurance contracts.-

3526 (1) As used in this section, the term:

3527 (a) "Policy" means a motor vehicle insurance policy that
3528 provides personal injury protection or emergency care coverage,
3529 or property damage liability coverage, or both.

3530 (b) "Binder" means a binder that provides motor vehicle
3531 personal injury protection or emergency care coverage and
3532 property damage liability coverage.

3533 (5) (a) A licensed general lines agent may charge a per-
3534 policy fee of up to ~~not to exceed~~ \$10 to cover the
3535 administrative costs of the agent associated with selling the
3536 motor vehicle insurance policy if the policy covers only
3537 personal injury protection or emergency care coverage as
3538 provided by s. 627.736 or s. 627.7485, as applicable, and
3539 property damage liability coverage as provided by s. 627.7275
3540 and if no other insurance is sold or issued in conjunction with
3541 or collateral to the policy. The fee is not considered part of
3542 the premium.

3543 (6) If a motor vehicle owner's driver license, license
3544 plate, and registration have previously been suspended pursuant
3545 to s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, an insurer may
3546 cancel a new policy only as provided in s. 627.7275.

3547 (7) A policy of private passenger motor vehicle insurance
3548 or a binder for such a policy may be initially issued in this
3549 state only if, before the effective date of such binder or
3550 policy, the insurer or agent ~~has~~ collected from the insured an



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3551 amount equal to 2 months' premium. An insurer, agent, or premium
3552 finance company may not, directly or indirectly, take any action
3553 resulting in the insured paying ~~having paid~~ from the insured's
3554 own funds an amount less than the 2 months' premium required by
3555 this subsection. This subsection applies without regard to
3556 whether the premium is financed by a premium finance company or
3557 is paid pursuant to a periodic payment plan of an insurer or an
3558 insurance agent.

3559 (a) This subsection does not apply:

3560 1. If an insured or member of the insured's family is
3561 renewing or replacing a policy or a binder for such policy
3562 written by the same insurer or a member of the same insurer
3563 group. ~~This subsection does not apply~~

3564 2. To an insurer that issues private passenger motor
3565 vehicle coverage primarily to active duty or former military
3566 personnel or their dependents. ~~This subsection does not apply~~

3567 3. If all policy payments are paid pursuant to a payroll
3568 deduction plan or an automatic electronic funds transfer payment
3569 plan from the policyholder.

3570 (b) This subsection and subsection (4) do not apply

3571 1. If all policy payments to an insurer are paid pursuant
3572 to an automatic electronic funds transfer payment plan from an
3573 agent, a managing general agent, or a premium finance company
3574 and if the policy includes, at a minimum, personal injury
3575 protection or emergency care coverage pursuant to ss. 627.730-
3576 627.7405 or ss. 627.748-627.7491, as applicable; motor vehicle
3577 property damage liability pursuant to s. 627.7275; and bodily
3578 injury liability in at least the amount of \$10,000 because of
3579 bodily injury to, or death of, one person in any one accident



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3580 and in the amount of \$20,000 because of bodily injury to, or
3581 death of, two or more persons in any one accident. ~~This~~
3582 ~~subsection and subsection (4) do not apply~~

3583 2. If an insured has had a policy in effect for at least 6
3584 months, the insured's agent is terminated by the insurer that
3585 issued the policy, and the insured obtains coverage on the
3586 policy's renewal date with a new company through the terminated
3587 agent.

3588 Section 52. Subsections (1), (2), and (3) of section
3589 627.737, Florida Statutes, are amended to read:

3590 627.737 Tort exemption; limitation on right to damages;
3591 punitive damages.—

3592 (1) Every owner, registrant, operator, or occupant of a
3593 motor vehicle with respect to which security has been provided
3594 as required by ss. 627.730-627.7405 or ss. 627.748-627.7491, as
3595 applicable, and every person or organization legally responsible
3596 for her or his acts or omissions, is ~~hereby~~ exempted from tort
3597 liability for damages because of bodily injury, sickness, or
3598 disease arising out of the ownership, operation, maintenance, or
3599 use of such motor vehicle in this state to the extent that the
3600 benefits described in s. 627.736(1) or s. 627.7485(1), as
3601 applicable, are payable for such injury, or would be payable but
3602 for any exclusion authorized by ss. 627.730-627.7405 or ss.
3603 627.748-627.7491, as applicable, under any insurance policy or
3604 other method of security complying with the requirements of s.
3605 627.733, or by an owner personally liable under s. 627.733 for
3606 the payment of such benefits, unless a person is entitled to
3607 maintain an action for pain, suffering, mental anguish, and
3608 inconvenience for such injury under the provisions of subsection



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3609 (2).

3610 (2) In any action of tort brought against the owner,
3611 registrant, operator, or occupant of a motor vehicle with
3612 respect to which security has been provided as required by ss.
3613 627.730-627.7405 or ss. 627.748-627.7491, as applicable, or
3614 against any person or organization legally responsible for her
3615 or his acts or omissions, a plaintiff may recover damages in
3616 tort for pain, suffering, mental anguish, and inconvenience
3617 because of bodily injury, sickness, or disease arising out of
3618 the ownership, maintenance, operation, or use of such motor
3619 vehicle only if ~~in the event that~~ the injury or disease consists
3620 in whole or in part of:

3621 (a) Significant and permanent loss of an important bodily
3622 function.

3623 (b) Permanent injury within a reasonable degree of medical
3624 probability, other than scarring or disfigurement.

3625 (c) Significant and permanent scarring or disfigurement.

3626 (d) Death.

3627 (3) If ~~When~~ a defendant, in a proceeding brought pursuant
3628 to ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable,
3629 questions whether the plaintiff has met the requirements of
3630 subsection (2), ~~then~~ the defendant may file an appropriate
3631 motion with the court, and the court shall, on a one-time basis
3632 only, 30 days before the date set for the trial or the pretrial
3633 hearing, whichever is first, by examining the pleadings and the
3634 evidence before it, ascertain whether the plaintiff will be able
3635 to submit some evidence that the plaintiff will meet the
3636 requirements of subsection (2). If the court finds that the
3637 plaintiff will not be able to submit such evidence, ~~then~~ the



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3638 court shall dismiss the plaintiff's claim without prejudice.

3639 Section 53. Section 627.8405, Florida Statutes, is amended
3640 to read:

3641 627.8405 Prohibited acts; financing companies.—~~A No~~ premium
3642 finance company ~~shall~~, in a premium finance agreement or other
3643 agreement, may not finance the cost of or otherwise provide for
3644 the collection or remittance of dues, assessments, fees, or
3645 other periodic payments of money for the cost of:

3646 (1) A membership in an automobile club. The term
3647 "automobile club" means a legal entity that ~~which~~, in
3648 consideration of dues, assessments, or periodic payments of
3649 money, promises its members or subscribers to assist them in
3650 matters relating to the ownership, operation, use, or
3651 maintenance of a motor vehicle; however, this definition of
3652 "automobile club" does not include persons, associations, or
3653 corporations that ~~which~~ are organized and operated solely for
3654 the purpose of conducting, sponsoring, or sanctioning motor
3655 vehicle races, exhibitions, or contests upon racetracks, or upon
3656 racecourses established and marked as such for the duration of
3657 such particular events. The term ~~words~~ "motor vehicle" has used
3658 ~~herein have~~ the same meaning as provided ~~defined~~ in s. 320.01
3659 ~~chapter 320~~.

3660 (2) An accidental death and dismemberment policy sold in
3661 combination with a personal injury protection and property
3662 damage only policy or an emergency care and property damage only
3663 policy, as applicable.

3664 (3) Any product not regulated under the ~~provisions of this~~
3665 insurance code.

3666



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3667 This section also applies to premium financing by any insurance
3668 agent or insurance company under part XVI. The commission shall
3669 adopt rules to assure disclosure, at the time of sale, of
3670 coverages financed with personal injury protection or emergency
3671 care coverage and ~~shall~~ prescribe the form of such disclosure.

3672 Section 54. Subsection (1) of section 627.915, Florida
3673 Statutes, is amended to read:

3674 627.915 Insurer experience reporting.—

3675 (1) Each insurer transacting private passenger automobile
3676 insurance in this state shall report certain information
3677 annually to the office. The information is ~~will be~~ due on or
3678 before July 1 of each year. The information shall be divided
3679 into the following categories: bodily injury liability; property
3680 damage liability; uninsured motorist; emergency care coverage or
3681 personal injury protection benefits; medical payments;
3682 comprehensive and collision. The information given must ~~shall~~ be
3683 on direct insurance writings in the state alone and ~~shall~~
3684 represent total limits data. The information set forth in
3685 paragraphs (a)-(f) is applicable to voluntary private passenger
3686 and Joint Underwriting Association private passenger writings
3687 and must ~~shall~~ be reported for each of the latest 3 calendar-
3688 accident years, with an evaluation date of March 31 of the
3689 current year. The information set forth in paragraphs (g)-(j) is
3690 applicable to voluntary private passenger writings and must
3691 ~~shall~~ be reported on a calendar-accident year basis ultimately
3692 seven times at seven different stages of development.

3693 (a) Premiums earned for the latest 3 calendar-accident
3694 years.

3695 (b) Loss development factors and the historic development



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3696 of those factors.

3697 (c) Policyholder dividends incurred.

3698 (d) Expenses for other acquisition and general expense.

3699 (e) Expenses for agents' commissions and taxes, licenses,
3700 and fees.

3701 (f) Profit and contingency factors as used ~~utilized~~ in the
3702 insurer's automobile rate filings for the applicable years.

3703 (g) Losses paid.

3704 (h) Losses unpaid.

3705 (i) Loss adjustment expenses paid.

3706 (j) Loss adjustment expenses unpaid.

3707 Section 55. Paragraph (d) of subsection (2) and paragraph
3708 (d) of subsection (3) of section 628.909, Florida Statutes, are
3709 amended to read:

3710 628.909 Applicability of other laws.—

3711 (2) The following provisions of the Florida Insurance Code
3712 shall apply to captive insurers who are not industrial insured
3713 captive insurers to the extent that such provisions are not
3714 inconsistent with this part:

3715 (d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as
3716 applicable, if when no-fault coverage is provided.

3717 (3) The following provisions of the Florida Insurance Code
3718 ~~shall~~ apply to industrial insured captive insurers to the extent
3719 that such provisions are not inconsistent with this part:

3720 (d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as
3721 applicable, if when no-fault coverage is provided.

3722 Section 56. Subsections (2) and (6) and paragraphs (a),
3723 (c), and (d) of subsection (7) of section 705.184, Florida
3724 Statutes, are amended to read:



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3725 705.184 Derelict or abandoned motor vehicles on the
3726 premises of public-use airports.—
3727 (2) The airport director or the director's designee shall
3728 contact the Department of Highway Safety and Motor Vehicles to
3729 notify that department that the airport has possession of the
3730 abandoned or derelict motor vehicle and to determine the name
3731 and address of the owner of the motor vehicle, the insurance
3732 company insuring the motor vehicle, notwithstanding ~~the~~
3733 ~~provisions of s. 627.736 or s. 627.7485, as applicable,~~ and any
3734 person who has filed a lien on the motor vehicle. Within 7
3735 business days after receipt of the information, the director or
3736 the director's designee shall send notice by certified mail,
3737 return receipt requested, to the owner of the motor vehicle, the
3738 insurance company insuring the motor vehicle, notwithstanding
3739 ~~the provisions of s. 627.736 or s. 627.7485, as applicable,~~ and
3740 all persons of record claiming a lien against the motor vehicle.
3741 The notice must ~~shall~~ state the fact of possession of the motor
3742 vehicle, that charges for reasonable towing, storage, and
3743 parking fees, if any, have accrued and the amount thereof, that
3744 a lien as provided in subsection (6) will be claimed, that the
3745 lien is subject to enforcement pursuant to law, that the owner
3746 or lienholder, if any, has the right to a hearing as set forth
3747 in subsection (4), and that any motor vehicle that ~~which~~, at the
3748 end of 30 calendar days after receipt of the notice, has not
3749 been removed from the airport upon payment in full of all
3750 accrued charges for reasonable towing, storage, and parking
3751 fees, if any, may be disposed of as provided in s.
3752 705.182(2)(a), (b), (d), or (e), including, but not limited to,
3753 ~~the motor vehicle~~ being sold free of all prior liens after 35



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3754 calendar days after the time the motor vehicle is stored if any
3755 prior liens on the motor vehicle are more than 5 years of age or
3756 after 50 calendar days after the time the motor vehicle is
3757 stored if any prior liens on the motor vehicle are 5 years of
3758 age or less.

3759 (6) The airport pursuant to this section or, if used, a
3760 licensed independent wrecker company pursuant to s. 713.78 shall
3761 have a lien on an abandoned or derelict motor vehicle for all
3762 reasonable towing, storage, and accrued parking fees, if any,
3763 except that a no storage fee may not shall be charged if the
3764 motor vehicle is stored less than 6 hours. As a prerequisite to
3765 perfecting a lien under this section, the airport director or
3766 the director's designee must serve a notice in accordance with
3767 subsection (2) on the owner of the motor vehicle, the insurance
3768 company insuring the motor vehicle, notwithstanding ~~the~~
3769 ~~provisions of s. 627.736 or s. 627.7485, as applicable,~~ and all
3770 persons of record claiming a lien against the motor vehicle. If
3771 attempts to notify the owner, the insurance company insuring the
3772 motor vehicle, ~~notwithstanding the provisions of s. 627.736,~~ or
3773 lienholders are not successful, the requirement of notice by
3774 mail shall be considered met. Serving of the notice does not
3775 dispense with recording the claim of lien.

3776 (7) (a) For the purpose of perfecting its lien under this
3777 section, the airport shall record a claim of lien which shall
3778 state:

3779 1. The name and address of the airport.

3780 2. The name of the owner of the motor vehicle, the
3781 insurance company insuring the motor vehicle, notwithstanding
3782 ~~the provisions of s. 627.736 or s. 627.7485, as applicable,~~ and



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3783 all persons of record claiming a lien against the motor vehicle.

3784 3. The costs incurred from reasonable towing, storage, and
3785 parking fees, if any.

3786 4. A description of the motor vehicle sufficient for
3787 identification.

3788 (c) The claim of lien shall be sufficient if it is in
3789 substantially the following form:

3790 CLAIM OF LIEN

3791 State of

3792 County of

3793 Before me, the undersigned notary public, personally
3794 appeared, who was duly sworn and says that he/she is the
3795 of, whose address is.....; and that the following
3796 described motor vehicle:

3797 ...(Description of motor vehicle)...

3798 owned by, whose address is, has accrued \$.... in
3799 fees for a reasonable tow, for storage, and for parking, if
3800 applicable; that the lienor served its notice to the owner, the
3801 insurance company insuring the motor vehicle notwithstanding ~~the~~
3802 ~~provisions of~~ s. 627.736 or s. 627.7485, Florida Statutes, as
3803 applicable, and all persons of record claiming a lien against
3804 the motor vehicle on, ...(year)..., by.....

3805 ...(Signature)...

3806 Sworn to (or affirmed) and subscribed before me this
3807 day of, ...(year)..., by ...(name of person making
3808 statement)....

3809 ...(Signature of Notary Public).....(Print, Type, or Stamp
3810 Commissioned name of Notary Public)...

3811 Personally Known....OR Produced....as identification.



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3812
3813 However, the negligent inclusion or omission of any information
3814 in this claim of lien which does not prejudice the owner does
3815 not constitute a default that operates to defeat an otherwise
3816 valid lien.

3817 (d) The claim of lien shall be served on the owner of the
3818 motor vehicle, the insurance company insuring the motor vehicle,
3819 notwithstanding ~~the provisions of s. 627.736 or s. 627.7485, as~~
3820 applicable, if no-fault coverage is provided, and all persons of
3821 record claiming a lien against the motor vehicle. If attempts to
3822 notify the owner, the insurance company insuring the motor
3823 vehicle ~~notwithstanding the provisions of s. 627.736, or~~
3824 lienholders are not successful, the requirement of notice by
3825 mail shall be considered met. The claim of lien shall be so
3826 served before recordation.

3827 Section 57. Paragraphs (a), (b), and (c) of subsection (4)
3828 of section 713.78, Florida Statutes, are amended to read:

3829 713.78 Liens for recovering, towing, or storing vehicles
3830 and vessels.-

3831 (4) (a) Any person regularly engaged in the business of
3832 recovering, towing, or storing vehicles or vessels who comes
3833 into possession of a vehicle or vessel pursuant to subsection
3834 (2), and who claims a lien for recovery, towing, or storage
3835 services, must ~~shall~~ give notice to the registered owner, the
3836 insurance company insuring the vehicle notwithstanding ~~the~~
3837 ~~provisions of s. 627.736 or s. 627.7485, as applicable~~, and to
3838 all persons claiming a lien thereon, as disclosed by the records
3839 in the Department of Highway Safety and Motor Vehicles or of a
3840 corresponding agency in any other state.



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3841 (b) If a ~~Whenever any~~ law enforcement agency authorizes the
3842 removal of a vehicle or vessel or if ~~whenever~~ any towing
3843 service, garage, repair shop, or automotive service, storage, or
3844 parking place notifies the law enforcement agency of possession
3845 of a vehicle or vessel pursuant to s. 715.07(2)(a)2., the law
3846 enforcement agency of the jurisdiction where the vehicle or
3847 vessel is stored shall contact the Department of Highway Safety
3848 and Motor Vehicles, or the appropriate agency of the state of
3849 registration, if known, within 24 hours through the medium of
3850 electronic communications, giving the full description of the
3851 vehicle or vessel. Upon receipt of the full description of the
3852 vehicle or vessel, the department shall search its files to
3853 determine the owner's name, the insurance company insuring the
3854 vehicle or vessel, and whether any person has filed a lien upon
3855 the vehicle or vessel as provided in s. 319.27(2) and (3) and
3856 notify the applicable law enforcement agency within 72 hours.
3857 The person in charge of the towing service, garage, repair shop,
3858 or automotive service, storage, or parking place shall obtain
3859 such information from the applicable law enforcement agency
3860 within 5 days after the date of storage and ~~shall~~ give notice
3861 pursuant to paragraph (a). The department may release the
3862 insurance company information to the requestor notwithstanding
3863 ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable.

3864 (c) Notice by certified mail, return receipt requested,
3865 shall be sent within 7 business days after the date of storage
3866 of the vehicle or vessel to the registered owner, the insurance
3867 company insuring the vehicle notwithstanding ~~the provisions of~~
3868 s. 627.736 or s. 627.7485, as applicable, and all persons of
3869 record claiming a lien against the vehicle or vessel. The notice



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3870 must ~~It shall~~ state the fact of possession of the vehicle or
3871 vessel, that a lien as provided in subsection (2) is claimed,
3872 that charges have accrued and the amount thereof, that the lien
3873 is subject to enforcement pursuant to law, and that the owner or
3874 lienholder, if any, has the right to a hearing as set forth in
3875 subsection (5), and that any vehicle or vessel that ~~which~~
3876 remains unclaimed, or for which the charges for recovery,
3877 towing, or storage services remain unpaid, may be sold free of
3878 all prior liens after 35 days if the vehicle or vessel is more
3879 than 3 years of age or after 50 days if the vehicle or vessel is
3880 3 years of age or less.

3881 Section 58. The Office of Insurance Regulation shall
3882 perform a data call relating to coverage under the Florida Motor
3883 Vehicle No-Fault Emergency Care Coverage Law and publish the
3884 results by January 1, 2015. It is the intent of the Legislature
3885 that the office design the data call with the expectation that
3886 the Legislature will use the data to help evaluate market
3887 conditions relating to motor vehicle insurance and the impact on
3888 the market of reforms made by this act. The elements of the data
3889 call must address, but need not be limited to, the following
3890 components of the new law:

- 3891 (1) Quantity of claims.
3892 (2) Type or nature of claimants.
3893 (3) Amount and type of benefits paid and expenses incurred.
3894 (4) Type and quantity of, and charges for, medical
3895 benefits.
3896 (5) Attorney fees related to bringing and defending actions
3897 for benefits.
3898 (6) Direct earned premiums for emergency care coverage,



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3899 pure loss ratios, pure premiums, and other information related
3900 to premiums and losses.

3901 (7) Licensed drivers and accidents.

3902 (8) Fraud and enforcement.

3903 Section 59. Any motor vehicle policy issued or renewed on
3904 or after January 1, 2013, is subject to and deemed to
3905 incorporate the Florida Motor Vehicle No-Fault Emergency Care
3906 Coverage Law as created by this act and is not subject to ss.
3907 627.730-627.7405, the Florida Motor Vehicle No-Fault Act.

3908 Section 60. If any provision of this act or its application
3909 to any person or circumstance is held invalid, the invalidity
3910 does not affect other provisions or applications of the act
3911 which can be given effect without the invalid provision or
3912 application, and to this end the provisions of this act are
3913 severable.

3914 Section 61. This act shall take effect January 1, 2013.

3915

3916 ===== T I T L E A M E N D M E N T =====

3917 And the title is amended as follows:

3918 Delete lines 14 - 96

3919 and insert:

3920 injury protection and emergency care coverage
3921 benefits; amending s. 400.991, F.S.; requiring that an
3922 application for licensure, or exemption from
3923 licensure, as a health care clinic include a statement
3924 regarding insurance fraud; amending s. 626.989, F.S.;
3925 providing that knowingly submitting false, misleading,
3926 or fraudulent documents relating to licensure as a
3927 health care clinic, or submitting a claim for personal



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3928 injury protection or emergency care coverage relating
3929 to clinic licensure documents, is a fraudulent
3930 insurance act under certain conditions; creating s.
3931 626.9895, F.S.; providing definitions; authorizing the
3932 Division of Insurance Fraud of the Department of
3933 Financial Services to establish a direct-support
3934 organization for the purpose of prosecuting,
3935 investigating, and preventing motor vehicle insurance
3936 fraud; providing requirements for, and duties of, the
3937 organization; requiring that the organization operate
3938 pursuant to a contract with the division; providing
3939 for the requirements of the contract; providing for a
3940 board of directors; authorizing the organization to
3941 use the division's property and facilities subject to
3942 certain requirements; requiring that the department
3943 adopt rules relating to procedures for the
3944 organization's governance and relating to conditions
3945 for the use of the division's property or facilities;
3946 authorizing contributions from insurers; authorizing
3947 any moneys received by the organization to be held in
3948 a separate depository account in the name of the
3949 organization; requiring that the division deposit
3950 certain proceeds into the Insurance Regulatory Trust
3951 Fund; amending s. 627.0651, F.S.; prohibiting certain
3952 costs and attorney fees awarded to plaintiffs in
3953 claims for benefits under the motor vehicle no-fault
3954 law from being included in insurance rates; amending
3955 s. 627.733, F.S.; providing that an owner or
3956 registrant of a motor vehicle does not have to comply



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3957 with this section if required security is obtained
3958 under the Florida Motor Vehicle No-Fault Emergency
3959 Care Coverage Law; amending s. 627.736, F.S. ;
3960 excluding massage and acupuncture from medical
3961 benefits that may be reimbursed under the motor
3962 vehicle no-fault law; requiring that an insurer give
3963 priority to the payment of death benefits under
3964 certain conditions; deleting provisions prohibiting
3965 the purchase of other motor vehicle coverage;
3966 requiring that an insurer repay any benefits covered
3967 by the Medicaid program within a specified time;
3968 requiring that an insurer provide a claimant an
3969 opportunity to revise claims that contain errors;
3970 requiring that an insurer create and maintain a log of
3971 benefits paid and that the insurer provide to the
3972 insured or an assignee of the insured, upon request, a
3973 copy of the log; requiring that an insurer notify
3974 parties in disputes over claims when policy limits are
3975 reached; revising the Medicare fee schedules that an
3976 insurer may use as a basis for limiting reimbursement
3977 of benefits; providing that the Medicare fee schedule
3978 in effect on a specific date applies for purposes of
3979 limiting such reimbursement; authorizing insurers to
3980 apply certain Medicare coding policies and payment
3981 methodologies; requiring that an insurer that limits
3982 payments based on the statutory fee schedule include a
3983 notice in insurance policies at the time of issuance
3984 or renewal; deleting obsolete provisions; providing
3985 that certain entities exempt from licensure as a



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3986 clinic must nonetheless be licensed to receive
3987 reimbursement for the provision of personal injury
3988 protection benefits; providing exceptions;
3989 consolidating provisions relating to unfair or
3990 deceptive practices under certain conditions;
3991 eliminating a requirement that all parties mutually
3992 and expressly agree for the use of electronic
3993 transmission of data; creating s. 627.748, F.S.;
3994 designating specified provisions as the Florida Motor
3995 Vehicle No-Fault Emergency Care Coverage Law; creating
3996 s. 627.7481, F.S.; providing purposes; creating s.
3997 627.74811, F.S.; providing legislative intent that
3998 provisions, schedules, or procedures are to be given
3999 full force and effect regardless of their express
4000 inclusion in insurer forms; creating s. 627.7482,
4001 F.S.; providing definitions; creating s. 627.7483,
4002 F.S.; requiring every owner or registrant of a motor
4003 vehicle required to be registered and licensed in this
4004 state to maintain specified security; providing
4005 exceptions; requiring every nonresident owner or
4006 registrant of a motor vehicle that has been physically
4007 present within this state for a specified period to
4008 maintain security; specifying means by which such
4009 security is provided; providing that an owner of a
4010 motor vehicle who fails to have such security is not
4011 immune to certain liabilities; providing an exemption;
4012 creating s. 627.7484, F.S.; providing requirements for
4013 filing and maintaining proof of security; providing
4014 penalties; creating s. 627.7485, F.S.; requiring that



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4015 insurance policies provide emergency care coverage to
4016 specified persons; providing limits of coverage;
4017 specifying limits for medical, disability, and death
4018 benefits; providing restrictions on insurers with
4019 respect to provision of required benefits; prohibiting
4020 an insurer from requiring the purchase of other motor
4021 vehicle coverage as a condition for providing such
4022 benefits; prohibiting an insurer from requiring the
4023 purchase of property damage liability insurance
4024 exceeding a specified amount in conjunction with
4025 emergency care coverage insurance; providing that
4026 failure to comply with specified availability
4027 requirements constitutes an unfair method of
4028 competition or an unfair or deceptive act or practice;
4029 providing penalties; authorizing an insurer to exclude
4030 certain benefits; providing procedure with respect to
4031 such exclusions; specifying when benefits are due from
4032 an insurer; prohibiting insurers from obtaining liens
4033 on recovery of special damages in tort claims for
4034 emergency care coverage benefits; prohibiting an
4035 insured party from recovering any damages for which
4036 emergency care coverage benefits are paid or payable;
4037 requiring that benefits received under any workers'
4038 compensation law be credited against the benefits
4039 provided under the emergency care coverage; providing
4040 that benefits under the Florida Motor Vehicle No-Fault
4041 Emergency Care Coverage Law are subject to the
4042 Medicaid program in specified circumstances;
4043 specifying injuries for which an insurer must pay



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4044 benefits; providing for notice to insurers; requiring
4045 insurers to hold a specified amount of benefits in
4046 reserve for a certain time for the payment of
4047 providers; requiring that an insurer create and
4048 maintain a log of benefits paid and that the insurer
4049 provide to the insured or an assignee of the insured,
4050 upon request, a copy of the log; specifying when
4051 benefits are overdue; providing for interest on
4052 overdue payments; authorizing an insurer to make
4053 certain assertions about a claim; requiring an insurer
4054 to provide an itemized specification of each item of a
4055 claim which has been reduced, omitted, or denied;
4056 providing that payment is not overdue if the insurer
4057 has reasonable proof that the insurer is not
4058 responsible for the payment; providing for a pro rata
4059 distribution of benefits paid and expenses if there
4060 are two or more insurers; requiring that an insurer
4061 notify parties in disputes over claims when policy
4062 limits are reached; providing for tolling the time
4063 period in which benefits are required to be paid when
4064 the insurer has reasonable belief that fraud has been
4065 committed; requiring that the insurer notify the
4066 claimant if the claim is being investigated for fraud;
4067 providing immunity to persons or entities that report
4068 suspected fraud in good faith; providing that an
4069 insurer who fails to timely provide benefits violates
4070 the insurance code; providing that a person or entity
4071 lawfully rendering treatment to an injured person for
4072 a bodily injury covered by emergency care coverage may



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4073 charge only a reasonable amount for services and care;
4074 providing that the insurer may pay such charges
4075 directly to the person or entity lawfully rendering
4076 such treatment; providing limits on such charges;
4077 providing for determination of reasonableness of
4078 charges; providing that payments made by an insurer
4079 pursuant to the schedule of maximum charges, or for
4080 lesser amounts billed by providers, are considered
4081 reasonable; establishing a schedule of maximum
4082 charges; specifying that reimbursement under a
4083 schedule of maximum charges which is based on Medicare
4084 is to be calculated under the applicable Medicare
4085 schedule in effect on a specified date each year;
4086 authorizing insurers to use all Medicare coding
4087 policies and CMS payment methodologies in determining
4088 reimbursement under a schedule of maximum charges
4089 which is Medicare based; establishing limits on
4090 specified emergency services and care; providing
4091 conditions under which an insurer or insured is not
4092 required to pay a claim or charges; requiring the
4093 Department of Health to adopt by rule a list of
4094 diagnostic tests deemed not to be medically necessary
4095 and to periodically revise the list; providing
4096 procedures and requirements with respect to statements
4097 of and bills for charges for emergency services and
4098 care; requiring that a notice of the insured's rights
4099 include a specified statement; requiring that a
4100 physician, licensed professional, clinic, or medical
4101 institution providing medical services require an



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4102 insured person to execute and countersign a disclosure
4103 and acknowledgement form; directing the Financial
4104 Services Commission to adopt by rule a disclosure and
4105 acknowledgment form to be countersigned by claimants
4106 upon receipt of medical services; providing procedures
4107 and requirements with respect to investigation of
4108 claims of improper billing by a physician or other
4109 medical provider; prohibiting insurers from
4110 systematically downcoding with intent to deny
4111 reimbursement; requiring insureds and persons to whom
4112 the right to payment for benefits has been assigned to
4113 comply with all terms of the policy; providing that
4114 compliance with policy terms is a condition precedent
4115 to the receipt of benefits; requiring that an employer
4116 furnish a sworn statement of an employee's earnings
4117 under certain circumstances; requiring that an
4118 insured's assignee comply with the terms of the
4119 insurance policy; prohibiting an insured from being
4120 required to submit to an examination under oath;
4121 requiring that all claimants produce and allow for the
4122 inspection of all documents requested by the insurer
4123 under certain circumstances; providing for insurers to
4124 inspect the physical premises of providers seeking
4125 payment; requiring that a provider seeking payment
4126 furnish to the insurer a written report; authorizing
4127 the insurer to petition the court to enter an order
4128 permitting discovery of facts under certain
4129 circumstances; requiring the insurer to furnish to the
4130 injured person a copy of all information; prohibiting



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4131 an insured from unreasonably withholding notice to an
4132 insurer of the existence of a claim; providing for the
4133 examination of the injured person and reports
4134 regarding the examination; prohibiting an insurer from
4135 withdrawing payment from a treating physician under
4136 certain circumstances; providing requirements with
4137 respect to a demand letter; providing procedures and
4138 requirements with respect to payment of an overdue
4139 claim; providing for the tolling of the time period
4140 for an action against an insurer; providing that
4141 failure to pay valid claims with specified frequency
4142 constitutes an unfair or deceptive trade practice;
4143 providing penalties; providing circumstances under
4144 which an insurer has a cause of action; providing for
4145 fraud advisory notice; requiring that all claims
4146 related to the same health care provider for the same
4147 injured person be brought in one action unless good
4148 cause is shown; authorizing the electronic
4149 transmission of notices and communications under
4150 certain conditions; creating s. 627.7486, F.S.;
4151 providing an exemption from tort liability for certain
4152 damages in legal actions under the Florida Motor
4153 Vehicle No-Fault Emergency Care Coverage Law in
4154 certain circumstances; providing for recovery of tort
4155 damages in certain circumstances; providing for
4156 motions to dismiss action on specified grounds;
4157 prohibiting a claim for punitive damages in excess of
4158 the coverage policy limits; creating s. 627.7487,
4159 F.S.; providing for optional deductibles and



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4160 limitations of coverage for emergency care coverage
4161 policies; requiring a specified notice to
4162 policyholders; creating s. 627.7488, F.S.; requiring
4163 the commission to adopt by rule a form for the
4164 notification of insureds of their right to receive
4165 emergency care coverage benefits; specifying contents
4166 of such notice; providing requirements for the mailing
4167 or delivery of such notice; creating s. 627.7489,
4168 F.S.; providing for mandatory joinder of specified
4169 claims; creating s. 627.749, F.S.; providing for an
4170 insurer's right of reimbursement for emergency medical
4171 care benefits paid to a person injured by a commercial
4172 motor vehicle under specified circumstances; creating
4173 s. 627.7491, F.S.; providing for application of the
4174 Florida Motor Vehicle No-Fault Emergency Care Coverage
4175 Law; providing for requirements for forms and rates
4176 for policies issued or renewed on or after a specified
4177 date; requiring a specified notice to existing
4178 policyholders; amending s. 817.234, F.S.; providing
4179 that it is insurance fraud to present a claim for
4180 personal injury protection or emergency care coverage
4181 benefits payable to a person or entity that knowingly
4182 submitted false, misleading, or fraudulent documents
4183 relating to licensure as a health care clinic;
4184 providing that a licensed health care practitioner who
4185 is found guilty of certain insurance fraud loses his
4186 or her license and may not receive reimbursement for
4187 personal injury protection or emergency care coverage
4188 benefits for a specified period; defining the term



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4189 "insurer"; conforming provisions; amending ss.
4190 316.065, 316.646, 318.18, 320.02, 320.0609, 320.27,
4191 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032,
4192 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072,
4193 626.9541, 626.9894, 627.06501, 627.0652, 627.0653,
4194 627.4132, 627.6482, 627.7263, 627.727, 627.7275,
4195 627.728, 627.7295, 627.737, 627.8405, 627.915,
4196 628.909, 705.184, 713.78, and 817.234, F.S.;
4197 conforming provisions; requiring that the Office of
4198 Insurance Regulation perform a data call relating to
4199 emergency care coverage and publish the results;
4200 prescribing required