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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:

400.991 License requirements; background screenings; prohibitions.—

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

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

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

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


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

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

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

2. Knowingly submits:

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

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


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

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

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

626.9895 Motor vehicle insurance fraud direct-support organization.—

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

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

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

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

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

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

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


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

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

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

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

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

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


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the organization by the division.

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

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

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

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

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

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

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

publications.

(4) BOARD OF DIRECTORS.—

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

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

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

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

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

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

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

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


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of Representatives.

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

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

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

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

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

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

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

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


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

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

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

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

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

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

627.733 Required security.—


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

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

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

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

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


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

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

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

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

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

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

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

b. A health care clinic that:

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

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


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

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

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

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

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


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

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

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


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

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

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

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


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

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

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


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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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

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


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with such frequency as to constitute a general business practice.

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

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

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

the limits have been reached.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

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

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

a. For emergency transport and treatment by providers


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licensed under chapter 401, 200 percent of Medicare.

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

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

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

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

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

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

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

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


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

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

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


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

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

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

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

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

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


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time rendered;

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

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

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

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

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


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

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


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

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

a. A denial letter from the incorrect insurer; or

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

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


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~~Administration~~.

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

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

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


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


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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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


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

(10) DEMAND LETTER.—

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

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


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

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

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

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

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


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

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


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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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


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

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

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

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

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

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


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100 percent owned by one or more hospitals or physicians.

2. A person or entity that certifies, upon the request of an insurer, that:

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

b. It is a 100 percent owner of medical equipment; and

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

(I) The repair or maintenance of existing 100 percent-owned medical equipment;

(II) The pending arrival and installation of newly purchased medical equipment or the replacement 100-percent-owned medical equipment; or

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

However, the 30-day lease period provided in this sub-subparagraph may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(b) As used in this subsection, the term "lessee" means a long-term lessee under a capital or operating lease but does not include a part-time lessee.


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

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

(3) "Emergency medical condition" means:

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

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

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

627.7483 Required security.—

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

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


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

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

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

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

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

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


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

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

627.7484 Proof of security; security requirements; penalties.—

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

(2) Any person who:

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


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believe that such information is false;

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

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

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

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

627.7485 Required emergency care coverage benefits.—

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

(a) *Medical benefits.*—

1. Eighty percent of all reasonable expenses for:

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

b. Emergency services and care rendered by a dentist,


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

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

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

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

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

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

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

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

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


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clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement for prescribed follow-up services and care under sub-subparagraph 1.d. unless the entity is:

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

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

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

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

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

3. Reimbursement for services provided by a chiropractic physician is limited to the lesser of 24 treatments or to services rendered within 12 weeks after the date of the initial chiropractic treatment, whichever comes first, unless the insurer authorizes additional chiropractic services.

4. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102.

5. For purposes of ss. 627.748-627.7491, a medical diagnosis that an emergency medical condition exists is presumed to be correct unless rebutted by clear and convincing evidence

to the contrary.

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

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

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

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

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

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

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

1. Causing injury to herself or himself intentionally; or

2. Being injured while committing a felony.

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

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

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

(4) PAYMENT OF BENEFITS.—

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


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

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

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

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

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

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

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

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


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such motor vehicle.

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

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

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

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

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

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

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

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


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

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

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

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

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

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


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2. Knowingly submitted false material information; or

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

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

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

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

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


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

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

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

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

for the service, treatment, supply, or care.

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

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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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


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

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

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

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

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

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

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reasonably relied on erroneous information from the insured and:

a. A denial letter from the incorrect insurer; or

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

(8) DEMAND LETTER.—

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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for such injury under subsection (2).

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

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

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

(c) Significant and permanent scarring or disfigurement; or

(d) Death.

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

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

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

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

627.7487 Emergency care coverage; optional limitations; deductibles.—

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

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

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

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

associated with that election.

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

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

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

627.7488 Notice of insured's rights.—

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

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

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

(b) An advisory informing insureds that:

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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

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

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

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


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with any questions she or he may have.

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

817.234 False and fraudulent insurance claims.—

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

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

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

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


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

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

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

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

(7)

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


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

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

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

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


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

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

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


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

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

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

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

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

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

316.065 Crashes; reports; penalties.—

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

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

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

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


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

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

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

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

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

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

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

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

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

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

320.02 Registration required; application for registration; forms.—

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


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

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


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

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

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

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

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


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

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

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

(1)

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

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

320.27 Motor vehicle dealers.—

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

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


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


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

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

320.771 License required of recreational vehicle dealers.—

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

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

The department shall, if it deems necessary, cause an


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

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

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

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

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

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

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


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~~shall~~ determine:

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

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

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

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

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

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

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


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

(9) OWNER; OWNER/LESSOR.—

(c) *Application.*—

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

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

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


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

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

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

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

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

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

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

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


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is not civilly liable for failing to provide this notice.

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

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

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

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


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

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

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

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

Upon request by the department, the applicant must provide the


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

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

324.171 Self-insurer.—

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

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

400.9935 Clinic responsibilities.—

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


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

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

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

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


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

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

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

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

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

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

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

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

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

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

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

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


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

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

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

456.072 Grounds for discipline; penalties; enforcement.—

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

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

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

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

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

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


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and unfair or deceptive acts or practices:

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

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

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


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accordance with the terms of the contract.

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

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

(I) Lawfully parked;

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

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

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

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


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traffic violation;

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

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

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

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

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

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

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


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

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

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

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

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


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

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

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

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

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

626.9894 Gifts and grants.—

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


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

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

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

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

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

627.0652 Insurance discounts for certain persons completing safety course.—

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


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

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

627.0653 Insurance discounts for specified motor vehicle equipment.—

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

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

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

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


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

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

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

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

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

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

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

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

primary; exception.—

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

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

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

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

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

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

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

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

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

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

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

627.7275 Motor vehicle liability.—

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

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

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

627.728 Cancellations; nonrenewals.—

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

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

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

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

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


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

627.7295 Motor vehicle insurance contracts.—

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

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

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

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

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

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


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

(a) This subsection does not apply:

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

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

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

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

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


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

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

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

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

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

(2).

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

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

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

(c) Significant and permanent scarring or disfigurement.

(d) Death.

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


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court shall dismiss the plaintiff's claim without prejudice.

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

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

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

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

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


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

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

627.915 Insurer experience reporting.—

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

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

(b) Loss development factors and the historic development

of those factors.

(c) Policyholder dividends incurred.

(d) Expenses for other acquisition and general expense.

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

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

(g) Losses paid.

(h) Losses unpaid.

(i) Loss adjustment expenses paid.

(j) Loss adjustment expenses unpaid.

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

628.909 Applicability of other laws.—

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

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

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

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

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


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

(2) The airport director or the director's designee shall contact the Department of Highway Safety and Motor Vehicles to notify that department that the airport has possession of the abandoned or derelict motor vehicle and to determine the name and address of the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and any person who has filed a lien on the motor vehicle. Within 7 business days after receipt of the information, the director or the director's designee shall send notice by certified mail, return receipt requested, to the owner of the motor vehicle, the insurance company insuring the motor vehicle, notwithstanding ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and all persons of record claiming a lien against the motor vehicle. The notice must ~~shall~~ state the fact of possession of the motor vehicle, that charges for reasonable towing, storage, and parking fees, if any, have accrued and the amount thereof, that a lien as provided in subsection (6) will be claimed, that the lien is subject to enforcement pursuant to law, that the owner or lienholder, if any, has the right to a hearing as set forth in subsection (4), and that any motor vehicle that ~~which~~, at the end of 30 calendar days after receipt of the notice, has not been removed from the airport upon payment in full of all accrued charges for reasonable towing, storage, and parking fees, if any, may be disposed of as provided in s. 705.182(2)(a), (b), (d), or (e), including, but not limited to, ~~the motor vehicle~~ being sold free of all prior liens after 35


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

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

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

1. The name and address of the airport.

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


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

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

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

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

CLAIM OF LIEN

State of ....

County of ....

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

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

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

...(Signature)...

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

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

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


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

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

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

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

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


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

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


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

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

(1) Quantity of claims.

(2) Type or nature of claimants.

(3) Amount and type of benefits paid and expenses incurred.

(4) Type and quantity of, and charges for, medical benefits.

(5) Attorney fees related to bringing and defending actions for benefits.

(6) Direct earned premiums for emergency care coverage,

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

(7) Licensed drivers and accidents.

(8) Fraud and enforcement.

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

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

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

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

And the title is amended as follows:

Delete lines 14 - 96

and insert:

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

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

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

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

insurance policies provide emergency care coverage to specified persons; providing limits of coverage; specifying limits for medical, disability, and death benefits; providing restrictions on insurers with respect to provision of required benefits; prohibiting an insurer from requiring the purchase of other motor vehicle coverage as a condition for providing such benefits; prohibiting an insurer from requiring the purchase of property damage liability insurance exceeding a specified amount in conjunction with emergency care coverage insurance; providing that failure to comply with specified availability requirements constitutes an unfair method of competition or an unfair or deceptive act or practice; providing penalties; authorizing an insurer to exclude certain benefits; providing procedure with respect to such exclusions; specifying when benefits are due from an insurer; prohibiting insurers from obtaining liens on recovery of special damages in tort claims for emergency care coverage benefits; prohibiting an insured party from recovering any damages for which emergency care coverage benefits are paid or payable; requiring that benefits received under any workers' compensation law be credited against the benefits provided under the emergency care coverage; providing that benefits under the Florida Motor Vehicle No-Fault Emergency Care Coverage Law are subject to the Medicaid program in specified circumstances; specifying injuries for which an insurer must pay

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


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charge only a reasonable amount for services and care; providing that the insurer may pay such charges directly to the person or entity lawfully rendering such treatment; providing limits on such charges; providing for determination of reasonableness of charges; providing that payments made by an insurer pursuant to the schedule of maximum charges, or for lesser amounts billed by providers, are considered reasonable; establishing a schedule of maximum charges; specifying that reimbursement under a schedule of maximum charges which is based on Medicare is to be calculated under the applicable Medicare schedule in effect on a specified date each year; authorizing insurers to use all Medicare coding policies and CMS payment methodologies in determining reimbursement under a schedule of maximum charges which is Medicare based; establishing limits on specified emergency services and care; providing conditions under which an insurer or insured is not required to pay a claim or charges; requiring the Department of Health to adopt by rule a list of diagnostic tests deemed not to be medically necessary and to periodically revise the list; providing procedures and requirements with respect to statements of and bills for charges for emergency services and care; requiring that a notice of the insured's rights include a specified statement; requiring that a physician, licensed professional, clinic, or medical institution providing medical services require an

insured person to execute and countersign a disclosure and acknowledgement form; directing the Financial Services Commission to adopt by rule a disclosure and acknowledgment form to be countersigned by claimants upon receipt of medical services; providing procedures and requirements with respect to investigation of claims of improper billing by a physician or other medical provider; prohibiting insurers from systematically downcoding with intent to deny reimbursement; requiring insureds and persons to whom the right to payment for benefits has been assigned to comply with all terms of the policy; providing that compliance with policy terms is a condition precedent to the receipt of benefits; requiring that an employer furnish a sworn statement of an employee's earnings under certain circumstances; requiring that an insured's assignee comply with the terms of the insurance policy; prohibiting an insured from being required to submit to an examination under oath; requiring that all claimants produce and allow for the inspection of all documents requested by the insurer under certain circumstances; providing for insurers to inspect the physical premises of providers seeking payment; requiring that a provider seeking payment furnish to the insurer a written report; authorizing the insurer to petition the court to enter an order permitting discovery of facts under certain circumstances; requiring the insurer to furnish to the injured person a copy of all information; prohibiting

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

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limitations of coverage for emergency care coverage policies; requiring a specified notice to policyholders; creating s. 627.7488, F.S.; requiring the commission to adopt by rule a form for the notification of insureds of their right to receive emergency care coverage benefits; specifying contents of such notice; providing requirements for the mailing or delivery of such notice; creating s. 627.7489, F.S.; providing for mandatory joinder of specified claims; creating s. 627.749, F.S.; providing for an insurer’s right of reimbursement for emergency medical care benefits paid to a person injured by a commercial motor vehicle under specified circumstances; creating s. 627.7491, F.S.; providing for application of the Florida Motor Vehicle No-Fault Emergency Care Coverage Law; providing for requirements for forms and rates for policies issued or renewed on or after a specified date; requiring a specified notice to existing policyholders; amending s. 817.234, F.S.; providing that it is insurance fraud to present a claim for personal injury protection or emergency care coverage benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents relating to licensure as a health care clinic; providing that a licensed health care practitioner who is found guilty of certain insurance fraud loses his or her license and may not receive reimbursement for personal injury protection or emergency care coverage benefits for a specified period; defining the term


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