A bill to be entitled

An act relating to personal injury protection insurance; providing an effective date.

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

Section 1. Subsection (5) of section 627.732, Florida Statutes, is amended and subsection (16) is added to read:

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

(5) "Owner" means a person who holds the legal title to a motor vehicle~~;~~ or~~,~~ a debtor or lessee who has the right to possession if a motor vehicle is the subject of a security agreement or lease with an option to purchase ~~in the event a motor vehicle is the subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, then the debtor or lessee shall be deemed the owner for the purposes of ss. 627.730-627.7405~~.

(16) “Physician” means a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459.

Section 2. Subsection (7) of section 627.733, Florida Statutes, is amended to read:

627.733 Required security.--

(7) Any operator or owner whose driver's license or registration has been suspended pursuant to 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 Highway Safety and Motor Vehicles of a nonrefundable reinstatement fee of $150 for the first reinstatement. Such

reinstatement fee shall be $250 for the second reinstatement and $500 for each subsequent reinstatement during the 3 years following the first reinstatement. Any person reinstating her or his insurance under this subsection must also secure noncancelable coverage as described in s. 627.7275(2) and present to the appropriate person proof that the coverage is in force on a form promulgated by the Department of Highway Safety and Motor Vehicles, such proof to be maintained for 2 years. If the person does not have a second reinstatement within 3 years after her or his initial reinstatement, the reinstatement fee shall be $150 for the first reinstatement after that 3-year period. In the event that a person's license and registration are suspended pursuant to this section or s. 316.646, only one reinstatement fee shall be paid to reinstate the license and the registration. All fees shall be collected by the Department of Highway Safety and Motor Vehicles at the time of reinstatement. The Department of Highway Safety and Motor Vehicles shall issue proper receipts for such fees and shall promptly deposit those fees in the General Revenue Fund ~~Highway Safety Operating Trust Fund. One-third of the fee collected under this subsection shall be distributed from the Highway Safety Operating Trust Fund to the local government entity or state agency which employed the law enforcement officer who seizes a license plate pursuant to s. 324.201. Such funds may be used by the local government entity or state agency for any authorized purpose~~.

Section 3. Subsections (1), (2), (5), (8), (10), and (11) of section 627.736, Florida Statutes, are amended and subsections (15) and (16) are added to read:

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

(1) REQUIRED BENEFITS.--Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(d), to a limit of not less than $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.—

1. One hundred percent of all allowable charges for:

a. Emergency transportation and treatment provided from the scene of the motor vehicle accident by an entity licensed under part III of chapter 401.

b. Emergency services and care, as defined in s. 395.002(1), provided in hospital where the patient presents at such facility within 72 hours of the motor vehicle accident.

c. Medically necessary non-emergency surgery and care and services directly related to the surgery, related to bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle.

2. One hundred percent of all allowable charges, up to a limit of the lesser of $5,000 or the remainder of unused benefits under the personal injury protection policy, for medically

necessary non-emergency services and care, related to bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle. The policy shall only provide reimbursement for such services and care if ordered by a physician or if provided by the following entities:

a. Physicians.

b. Chiropractic physicians licensed under chapter 460.

c. Dentists licensed under chapter 466.

d. Entities wholly owned by one or more physicians, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466, or by such practitioner or practitioners and the spouse, parent, child or sibling of that practitioner or those practitioners.

e. Hospitals.

f. Entities wholly owned, directly or indirectly, by a hospital or hospitals.

g. Entities licensed under part X of chapter 400 that maintain a medical director licensed under chapter 458, chapter 459, or chapter 460, have been continuously licensed for more than 3 years, or are either publicly traded or part of a controlled group of companies as defined by the Internal Revenue Service Code. Each facility must provide at least four of the following medical specialties:

(I) General medicine.

(II) Radiography.

(III) Orthopedic medicine.

(IV) Physical medicine.

(V) Physical therapy.

(VI) Physical rehabilitation.

(VII) Prescribing or dispensing outpatient prescription medication.

(VIII) Laboratory services.

h. Entities accredited by an accrediting organization as defined in s. 395.002.

~~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. Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies upon spiritual means through prayer alone for healing, in accordance with his or her religious beliefs; however, this sentence does not affect the determination of what other services or procedures are medically necessary.~~

(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 shall be paid not less than every 2 weeks.

(c) Death benefits.--Death benefits of up to the lesser of $5,000 or the remainder of unused benefits under the personal injury protection policy per individual. The insurer may pay 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 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 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.

(2) AUTHORIZED EXCLUSIONS.—

(a) Any insurer may exclude benefits:

1. For injury sustained by the named insured and relatives residing in the same 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.

2. To an injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

a. Causing injury to himself or herself intentionally; or

b. Being injured while committing a felony.

3. Not meeting the requirements set forth in subparagraph (1)(a)2.

(b) Whenever an insured is charged with conduct as set forth in subparagraph 2.b., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection 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.

(c) An insurer shall establish documentation requirements consistent with industry standards for providers to establish eligibility for reimbursement pursuant to the criteria set forth in subparagraph (1)(a)2. An insurer may exclude payment for such treatment and care if the provider does not sufficiently document that it meets those criteria.

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

(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 not charge the insurer and injured party more than ~~only~~ the usual and customary 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 be in excess of the usual and customary amount charged for similar services or supplies in the community where the services or supplies were provided ~~the person or institution customarily charges for like services or supplies~~. ~~With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.~~

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

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

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

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

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

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good faith effort to do so, as documented in the insurer's file; 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. Charges for medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, and surface electromyography shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule or other payment methodology established pursuant to s. 440.13.~~

~~3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing when done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter~~

~~459, chapter 460, or chapter 461 who is also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor.~~

~~4. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing that does not meet the requirements of subparagraph 3. shall not exceed the applicable fee schedule or other payment methodology established pursuant to s. 440.13.~~

2. ~~5.~~ Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for the year in which the services were provided ~~for year 2001~~, for the area in which the treatment was rendered~~, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United~~

~~States Department of Labor for the 12-month period ending June 30 of that year, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the Accreditation Association for Ambulatory Health Care, the American College of Radiology, or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor for the 12-month period ending June 30 of that year~~. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395.

~~6. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The initial list shall be adopted by January 1, 2004, and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list of invalid diagnostic tests shall be based on lack of demonstrated~~

~~medical value and a level of general acceptance by the relevant provider community and 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 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 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~~. With respect to any treatment or service billed by a hospital 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 45 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. The injured party is not liable for, and the provider shall not bill

the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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.

~~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 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 Centers for Medicare and Medicaid ServicesHealth Care Finance Administration.~~

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

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, ~~other than certain hospital and emergency services,~~ the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 45 days by a hospital and more than 35 days by other providers 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~~.

4. An insurer shall give priority in payment of claims to any timely submitted claim by a physician rendering care in a hospital within 72 hours after the automobile accident.

(d) All statements and bills for medical services rendered by 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

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

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical

institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

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

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

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

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

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

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

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other

services that are of such a nature that they are not required to be performed in the presence of the insured.

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

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

6. 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 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, "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, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine 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 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.

(8) APPLICABILITY OF PROVISION REGULATING 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 s. 627.428 shall apply, except as provided in subsection (11) and except that any attorney’s fees recovered under ss. 627.730-627.7405 shall be limited to the greater of $5,000 or three (3) times the amount of benefits secured by the attorney under ss. 627.730- 627.7405.

(10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, ~~and~~ 463, and 466. The insurer may provide an option to an insured to elect ~~use~~ a preferred provider policy at the time of 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, the insurer may require a deductible not to exceed $1000. The insurer shall not require a deductible for services and care covered pursuant to section (1)(a)1. ~~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.~~ The deductible shall apply to the named insured alone or to the named insured and the dependent relatives residing in the same household, but shall not apply to any other person covered under the policy. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer must offer

the preferred provider policy to a policyholder at a lower cost than the nonpreferred provider policy. The insurer shall provide each 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 principal office of the insurer within the state.

(11) MANAGED CARE POLICIES.--An insurer may provide an option for the insured to elect a managed care policy to provide any portion of the medical benefits described in this section, if the requirements of this subsection are met. The insurer may offer a managed care policy by contracting with an insurer licensed under chapter 627, a health flex plan entity approved under s. 408.908, or with a managed care organization licensed under chapter 641, including a health maintenance organization or a prepaid clinic organization. If the insured elects to use a provider who is not covered by the the managed care policy, the insurer may require a deductible not to exceed $1000. The insurer shall not require a deductible for services and care covered pursuant to section (1)(a)1. The deductible shall apply to the named insured alone or to the named insured and the dependent relatives residing in the same household, but shall not apply to any other person covered under the policy. The insurer must offer the managed care policy to a policyholder at a lower cost than the non-managed care policy. The insurer shall provide each policyholder with a current roster of managed care 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 principal office of the insurer within the state.

(12) DEMAND LETTER.--

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may be sent no earlier than 45 days after a claim is submitted for payment. ~~Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b)~~.

(b) The notice required shall state that it is a "demand letter under s. 627.736(11)" and shall state with specificity:

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

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

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

and duration of future treatment claimed to be reasonable and medically necessary.

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

(d) If, within 15 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 15 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 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 shall not be obligated to pay any 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 15 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.

(16) ADDITIONAL BENEFITS – Subject to the terms and limitation of this chapter and the insurance policy, an insurer may offer a policy for personal injury protection coverage with a limit of more than $10,000 and may offer a policy for personal injury protection coverage with a limit of more than $5,000 for coverage under section (1)(a)2.

(17) SECURE ELECTRONIC DATA TRANSFER.--Any electronic notice, documentation, transmission, or communication of any kind required or permitted under ss. 627.730-627.7405 must be

transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Section 4. Section 627.739, Florida Statutes, is amended to read:

627.739 Personal injury protection; 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 same household, but may not elect a deductible or modified coverage to apply to any other person covered under the policy.~~

(1)~~(2) Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, and $1,000.~~ Any ~~The~~ deductible allowed under s. 627.736(10) ~~amount~~ must be applied to 100 percent of the expenses and losses described in s. 627.736. After the deductible is met, each insured is eligible to receive up to the policy limit in total benefits described in s. 627.736(1). However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

(2)~~(3)~~ Insurers shall offer coverage wherein, at the election of the named insured, the benefits for loss of gross income and loss of earning capacity described in s. 627.736(1)(b) shall be excluded.

~~(4) The named insured shall not be prevented from electing a deductible under subsection (2) and modified coverage under subsection (3).~~ Each election made by the named insured under

this section shall result in an appropriate reduction of premium associated with that election.

(3)~~(5)~~ All such offers shall be made in clear and unambiguous language at the time the initial application is taken and prior to each annual renewal and shall indicate that a premium reduction will result from each election. At the option of the insurer, the requirements of the preceding sentence are 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 personal injury protection insurance, the named insured may elect ~~a deductible and~~ to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). This election applies ~~These elections apply~~ to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

Section 5. Section 627.7261, Florida Statutes, is amended to read:

627.7261 Prior denial of coverage; volunteer driver; effect on coverage or rate ~~Refusal to issue policy~~.--

(1) No insurer may deny an application for automobile liability insurance solely on the ground that:

(a) Renewal of similar coverage has been denied by another

insurer or on the ground of an applicant's failure to disclose that such denial has occurred; or

(b) The applicant is a volunteer driver.

(2) No insurer may impose a surcharge or otherwise increase the rate for an automobile liability policy solely on the basis that the named insured, a member of the insured's household, or a person who customarily operates the insured's vehicle is a volunteer driver. This subsection does not prohibit an insurer from refusing to renew, imposing a surcharge, or otherwise raising the rate for an automobile liability insurance policy based upon factors other than the volunteer status of the insured driver.

(3) For purposes of this section, the term "volunteer driver" means a person who provides services, including transporting individuals or goods, without compensation above expenses to a private nonprofit agency as defined in s. 273.01 or charitable organization as defined in s. 736.1201.

Section 6. Paragraph (c) 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:

(c) "Nonpayment of premium" means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. "Nonpayment of

premium" also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer.~~; further,~~ If the dishonored check represents the initial premium payment, the contract and all contractual obligations shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party shall be refunded to that party in full. If a dishonored check is made payable to the insurer, the insurer may cancel the policy in accordance with paragraph (3)(a).

Section 7. Section 627.736 Required personal injury protection benefits; exclusions; priority; claims.-

(12) Any insurer making a general business practice of not paying valid claims under the Florida No-Falut Law is engaging in an unfair trade practice under the insurance code. Notwithstanding section 501.212, the Department of Legal Affairs shall have the power to investigate and initiate actions for any violations of this paragraph, including, without limitation, pursuant to Chapter 501, Part II.

Section 7. Section 627.7404, Florida Statutes, is created to read:

Interpleader. An action for interpleader or in the nature of interpleader may be brought against two or more adverse claimants who claim or may claim entitlement to benefits that may be available pursuant to a policy of motor vehicle insurance. The

claims of the several defendants need not have a common origin or be identical but may be adverse to and independent of each other. The plaintiff may deny liability in whole or in part to any or all of the defendants. A defendant may likewise obtain interpleader by way of counterclaim or cross-claim. The complaint for interpleader shall specify the nature and value of the benefits and must be accompanied by payment or tender into court of the benefits available. The complaint may request, and the court may grant prior to the entry of an order of interpleader, appropriate ancillary relief, including, but not limited to, preliminary injunctive relief. Interpleading of policy limits shall be prima facie evidence of good faith on the part of the insurance company. No part of this action shall limit in any way the joinder of parties otherwise permitted by Florida law.

Section 8. Subsection (1) of section 627.901, Florida Statutes, is amended to read:

627.901 Premium financing by an insurance agent or agency.--

(1) A general lines agent may make reasonable service charges for financing insurance premiums on policies issued or business produced by such an agent or agency, s. 626.9541 notwithstanding. The service charge shall not exceed $5 ~~3~~ per installment. The maximum service charge shall not exceed $60 ~~36~~ per year. The service charge would also be permissible from the insured when the agent processes, as a convenience and accommodation to the insured, an installment payment from the insured to the insurance company or premium finance company when such payments can be made directly to the insurance company or premium finance company by the insured. In no case may an agent

collect more than one service charge on any one payment. In lieu of such service charges, an insurance agent or agency, at the sole discretion of such agent or agency, may charge a rate of interest not to exceed 18 percent simple interest per year on:

(a) The unpaid balance; or

(b) The average unpaid balance as billed over the term of the policy and subject to endorsement changes. The interest authorized by this paragraph may be billed in equal installments.

Section 9. Effective January 1, 2012, sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes, constituting the Florida Motor Vehicle No-Fault Law, are repealed unless reviewed and reenacted by the Legislature before that date.

Section 10. Section 19 of chapter 2003-411, Laws of Florida, is repealed, and sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes, are reenacted and shall not stand repealed on October 1, 2007, as provided for in that section.

Section 11. For the 2007-2008 fiscal year, the nonrecurring sum of $2 million is appropriated from the General Revenue Fund to the Insurance Regulatory Trust Fund for the purpose of providing grants to local law enforcement agencies for the prevention and prosecution of automobile insurance claims fraud. The Department of Financial Services shall administer the grants and shall give priority to local law enforcement agencies within regions of the state with the highest incident of fraud related to the Florida Motor Vehicle No-Fault Law.

Section 12. Effective upon this act becoming a law, section 19 of chapter 2003-411, Laws of Florida, is repealed, and

sections 627.730, 627.731, 627.732, 627.733, 637.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes, are reenacted and shall not stand repealed on October 1, 2007, as provided for in that section.

Section 13. Effective upon this act becoming a law and notwithstanding the provisions of s. 627.7277 or s. 627.728, an insurer may renew or cancel a policy with notice of at least five days prior to the renewal or cancellation if the exclusive reason for such renewal or cancellation of the policy is to issue the insured a policy that compiles with the provisions of s. 627.733 and s. 627.736. This section expires January 15, 2008.

Section 14. This act shall take effect January 1, 2008 except as otherwise provided.