A bill to be entitled

An act relating to personal injury protection insurance; amending s. 26.012, F.S.; providing that circuit courts have exclusive original jurisdiction of unresolved arbitration actions involving the Florida Motor Vehicle No-Fault Law; amending s. 627.4137, F.S.; requiring requests made to a self-insured corporation for disclosure of certain information to be by certified mail; amending s. 627.731, F.S.; providing legislative intent; amending s. 627.736, F.S.; revising a reference to Medicare Part B payments as the schedule for an insurer's discretionary use when limiting reimbursement of certain medical services, supplies, and care; specifying the Medicare fee schedule or payment limitation that is to be used by an insurer to limit reimbursements for certain medical services, supplies, and care; requiring both the insured and any assignee of benefits or payments to cooperate under the terms of the policy; requiring a provider who is assigned the benefits of an insured to submit to examination under oath under certain circumstances; requiring a provider to produce certain knowledgeable individuals for examination under oath under certain circumstances; requiring certain records be provided by claimants for inspection if requested by an insurer; authorizing methods for recording examinations under oath; providing that certain actions by an insurer constitute an unfair and deceptive trade practice; subjecting insurers to penalties for an unfair and deceptive trade practice;

creating a presumption relating to failing to appear for an examination; specifying that submitting to an examination is a condition precedent to recovering benefits; providing for application relating to attorney's fees; limiting the amount of recoverable attorney's fees; prohibiting the use of a contingency risk multiplier when calculating attorney's fees; authorizing binding arbitration as a policy provision for dispute resolution; providing requirements and procedures relating to arbitration; providing for the recovery of specified attorney's fees and costs by a prevailing party in arbitration; defining prevailing party; providing for judicial appeal of an arbitration award; providing for the scope of review on appeal; providing an effective date.

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

Section 1. Subsection (2) of section 26.012, Florida Statutes, is amended to read:

26.012 Jurisdiction of circuit court.—

(2) They shall have exclusive original jurisdiction:

(a) In all actions at law not cognizable by the county courts.~~;~~

(b) Of proceedings relating to the settlement of the estates of decedents and minors, the granting of letters testamentary, guardianship, involuntary hospitalization, the determination of incompetency, and other jurisdiction usually pertaining to courts of probate.~~;~~

(c) In all cases in equity including all cases relating to juveniles except traffic offenses as provided in chapters 316 and 985.~~;~~

(d) Of all felonies and of all misdemeanors arising out of the same circumstances as a felony which is also charged.~~;~~

(e) In all cases involving legality of any tax assessment or toll or denial of refund, except as provided in s. 72.011.~~;~~

(f) In actions of ejectment.~~; and~~

(g) In all actions involving the title and boundaries of real property.

(h) In all actions not resolved by arbitration involving the Florida Motor Vehicle No-Fault Law, codified in ss. 627.730-627.7407.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation under this section must be sent via United States certified mail to the registered agent of the disclosing entity.

Section 3. Section 627.731, Florida Statutes, is amended to read:

627.731 Purpose and legislative intent.—

(1) The purpose of ss. 627.730-627.7405 is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles required to be registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain,

suffering, mental anguish, and inconvenience.

(2) It is the intent of the Legislature to balance the insured's interest in prompt payment of valid claims for no-fault insurance benefits with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. To these ends, the intent of this act is to enhance the investigation and prevention of fraudulent insurance acts in this state, to remove incentives for manufactured litigation, and to revise provisions of law that may create incentives for fraudulent insurance acts. As such, ss. 627.730-627.7405 shall be construed according to the plain language of the statutory provisions which are designed to meet these goals.

(3) It is the further intent of the Legislature that the provisions, schedules, and procedures authorized in ss. 627.730-627.7405 be implemented by the insurers who offer personal injury protection benefits. Provisions, schedules, and procedures authorized in ss. 627.730-627.7405 have full force and effect regardless of their inclusion in an insurance policy form, and an insurer is not required to amend its policy form to utilize provisions, schedules, or procedures specifically authorized by the Florida Motor Vehicle No-Fault law.

Section 4. Paragraph (a) of subsection (5), paragraph (b) of subsection (6), paragraph (b) of subsection (7), and subsection (8) of section 627.736, Florida Statutes, are amended, present subsection (16) is redesignated as subsection (17), and new subsections (16) and (18) are added to that section, to read:

627.736 Required personal injury protection benefits;

exclusions; priority; claims.—

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)1. 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 be in excess of the amount 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.

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

a. For emergency transport and treatment by providers 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, <u>including durable medical equipment and care and services rendered by clinical laboratories,</u> 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, <u>or if the care and services are rendered in an ambulatory surgical center,</u> 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.

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

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

5. If an insurer limits payment as authorized by subparagraph 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.

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against

any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code. If an insured seeking to recover benefits under ss. 627.730-627.7405 assigns the contractual right to those benefits or the payment of those benefits to any person or entity, the assignee shall comply with the terms of the policy, and both the insured and the assignee shall be obligated to cooperate under the policy, which includes, but is not limited to, submitting to examinations under oath. Compliance with this paragraph is a condition precedent to the recovery of benefits under ss. 627.730-627.7405. If an insurer requests an examination under oath of a medical provider, the provider must produce those individuals

with the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer that are reasonably obtainable by the claimant. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof. Any insurer that, as a general practice, requests examinations under oath without a reasonable basis is engaging in an unfair and deceptive trade practice.

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

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports 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, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit

to an examination, the personal injury protection carrier is no longer liable for ~~subsequent~~ personal injury protection benefits incurred after the date of the first request for examination. Failure to appear for an examination creates a rebuttable presumption that the failure was an unreasonable refusal. Submission to an examination is a condition precedent to benefits.

(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, or between any entity or person seeking payment of benefits pursuant to the terms of the policy, the provisions of s. 627.428 shall apply, except as provided in subsections (10), (15), and (18)~~(15)~~. Any attorney's fees recovered under ss. 627.730-627.7405 shall be limited to the lesser of $10,000 or treble the disputed amount recovered by the attorney under ss. 627.730-627.7405. Attorney's fees in a class action under ss. 627.730-627.7405 are limited to the lesser of $50,000 or treble the total of the disputed amount recovered in the class action proceeding.

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

(17)~~(16)~~ SECURE ELECTRONIC DATA TRANSFER.—If all parties mutually and expressly agree, a notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data

transfer that is consistent with state and federal privacy and security laws.

(18) ARBITRATION; APPEALABLE BY ACTION IN CIRCUIT COURT.—

(a) In order to expedite the resolution of disputes arising from contracts involving personal injury protection benefits, an insurer may offer a policy that requires or allows the insurer, an insured, or any other claimant under the policy to make a demand for arbitration for any claims dispute involving personal injury protection benefits before filing a lawsuit and in lieu of litigation, with the exception of an appeal pursuant to paragraph (i). Before making a demand for arbitration, a claimant must comply with the conditions under subsection (10). A demand for arbitration must be in writing and furnished to the nonrequesting party via United States certified mail. Arbitration may not be held until at least 30 days after the request for arbitration is received by the nonrequesting party and at least 20 days after all the requested documentation discoverable under paragraphs (e) and (f) is received. Unless otherwise provided in this subsection, arbitration is governed by chapter 682, the Florida Arbitration Code.

(b) The arbitration must take place in the county where the treatment was rendered. If the treatment was rendered outside this state, arbitration must take place in the county where the insured resides, unless the parties agree to another location.

(c) The arbitration panel must be made up of three arbitrators. Each party must select a competent and impartial arbitrator. The two arbitrators selected by the parties must

select a third arbitrator. If the two arbitrators selected by the parties are unable to agree on the selection of a third arbitrator within 30 days, either party may request a circuit court judge in the county where the arbitration is pending to select a third arbitrator. If this method fails or for any reason cannot be followed, or an arbitrator who has been appointed fails to act and a successor has not been duly appointed, the court, on application of an insurer or claimant, must appoint one or more arbitrators. An arbitrator so appointed has the same powers as an arbitrator named or provided for in the policy providing personal injury protection benefits.

(d) The decision of a majority of the arbitrators is binding on each party, unless appealed under paragraph (i). The decision of the arbitrators must be furnished in writing to each party.

(e) Upon written request before arbitration, the appropriate provider must make available for inspection or copying the entire file pertaining to the patient whose benefits are the subject of arbitration. Arbitration may not be held until 30 days after the required written demand for arbitration is received and an insured's file is supplied to the insurer.

(f) Upon written request before arbitration, the insurer must provide for the inspection or copying of the evidence upon which it relies in adjusting or rejecting the claim. However, the insurer is not required to produce privileged items from its claims or underwriting files or documents or items which it does not intend to rely upon as evidence to support its adjustment or rejection of the claim. This paragraph only authorizes discovery

from the insurer of items relating to insurance coverage and does not authorize discovery pertaining to any issue relating to the handling of claims.

(g) An arbitration award may not exceed the applicable limits of coverage remaining on the policy.

(h)1. The prevailing party is entitled to reimbursement of reasonable attorney's fees and costs directly associated with the arbitration. A claim for attorney's fees is limited to the lesser of $10,000 or treble the amount of the benefits secured in the arbitration process, or in the case of a class action, attorney's fees are limited to the lesser of $50,000 or treble the total amount of the benefits secured in the arbitration process.

2. For purposes of this section, the prevailing party is:

a. The claimant if the award is greater than 50 percent above the amount the insurer offered before arbitration; or

b. The insurer if the award is less than 50 percent above the amount the insurer offered before arbitration.

3. If there is no prevailing party, each party must pay its own costs and attorney's fees and share equally in the payment of the costs incurred on both parties' behalf, including the costs of a third arbitrator.

(i) Either party may appeal the arbitration decision by filing an appeal in circuit court with a copy of the arbitration decision attached. However, if the insurer pays the amount awarded in the arbitration, but the claimant, assignee, or insured seeking benefits under the insurance policy appeals the arbitration decision in circuit court, s. 627.428 does not

apply. An appeal of the arbitration decision is limited to a review on the record and is not a de novo review. Interest on the amount in dispute does not accrue during the course of an appeal.

Section 5. This act shall take effect upon becoming a law.