A bill to be entitled

An act relating to insurance; amending s. 624.155, F.S.; revising requirements and procedures for the civil remedy notice provided to insurers and the Department of Financial Services; revising the period the statute of limitations is tolled; revising the timeframe for an insurer to pay damages or for certain circumstances to be corrected; creating a duty of good faith by persons claiming against an insurer; providing that an insurer does not violate its good faith duty to settle claims and is not liable for a certain failure if it meets certain conditions; providing a limitation on an insurer's liability to third-party claimants, under certain circumstances; requiring insureds, claimants, or their representatives to act in good faith; creating a defense where the insured, claimant, or claimant's representative has failed to make good faith efforts to cooperate with the insurer's investigations; amending s. 624.422, F.S.; requiring insurers to file certain contact information for the department to forward civil remedy notices; amending s. 627.736, F.S.; revising allowable maximum medical charges; specifying information required as part of a presuit notice in motor vehicle personal injury protection

claims; requiring information relating to treatment, services, and accommodations provided to claimants; requiring the identification of payments in dispute; requiring claimants to comply with notice requirements; prohibiting relief to claimants in certain circumstances; awarding attorney fees and certain costs and disbursements in certain circumstances; providing an effective date.

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

Section 1. Subsection (3) of section 624.155, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

624.155 Civil remedy.—

(3)(a) As a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days' written notice of the violation. Notice to the authorized insurer must be forwarded by the department to the insurer at the e-mail address designated by the insurer under s. 624.422. The 60 days shall begin tolling when the department receives an e-mail notice of receipt from the insurer.

(b) The notice shall be on a form provided by the department and shall state with specificity the following

information, and such other information as the department may require:

1. The statutory provision, including the specific language of the statute, which the authorized insurer allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third party claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the third party claimant pursuant to written request.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

6. Proof of the insured's legal liability and damages which have become clear with supporting documentation.

(c)1. No action shall lie if, within 60 days after the insurer receives ~~filing~~ notice from the department in accordance with this subsection, the damages are paid or the circumstances giving rise to the violation are corrected.

2. A third-party claimant shall have no action under subparagraph (1)(b)1. if:

a. There is a single claimant in a liability claim and the insurer offers the lesser of policy limits or the claimant's demand prior to the end of the 60 days, including the period prior to the 60 days; or

b. If there are two or more claimants in a liability claim making claims arising out of a single occurrence which in total exceed the available policy limits of one or more of the insured parties who may be liable to the claimants, an insurer is not liable beyond the available policy limits for failure to pay all or any portion of the available policy limits to one or more of the claimants, if within 90 days after receiving notice of the second claim or during the 60 days the insurer files an interpleader action under the Florida Rules of Civil Procedure. The claimants are entitled to a prorated share of the policy limits as determined by the trier of fact. An insurer's interpleader action does not alter or amend the insurer's obligation to defend its insured. Upon disbursement of interplead funds, claimants who receive said funds shall execute releases in favor of the insured party or parties.

(d) The authorized insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(e) The applicable statute of limitations for an action under this section shall be tolled for a period of 60 ~~65~~ days after the insurer receives from the department ~~by the mailing of~~

the notice required by this subsection ~~or the mailing of a subsequent notice required by this subsection~~.

(f) A notice required under this subsection may not be filed within 60 days after appraisal is invoked by any party in a residential property insurance claim.

(10) The insured, claimant, or representative of the insured or claimant has a duty to act in good faith in furnishing information regarding a claim, in making demands of the insurer, in setting deadlines, and in attempts to settle the claim. This duty does not create a separate cause of action and may only be used as a defense against damages awarded pursuant to this subsection. It shall be a defense to a claim of bad faith that the claimant, claimant's representative, or insured failed to make good faith efforts to cooperate with the insurer in the investigation of the claim.

Section 2. Subsection (2) of section 624.422, Florida Statutes, is amended to read:

624.422 Service of process; appointment of Chief Financial Officer as process agent.—

(2) Prior to its authorization to transact insurance in this state, each insurer shall file with the department designation of the name and address of the person to whom process against it served upon the Chief Financial Officer is to be forwarded. Each insurer shall also file with the department designation of the name and e-mail address of the person to whom

the department shall forward civil remedy notices filed under s. 624.155. The insurer may change a ~~the~~ designation at any time by a new filing.

Section 3. Paragraph (a) of subsection (5) and subsection (10) of section 627.736, Florida Statutes, are amended to read:

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

(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 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. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining 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, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. 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, 200 percent of Medicare ~~75 percent of the hospital's usual and customary charges~~.

c. For emergency services and care as defined by s. 395.002 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, 200 percent of Medicare ~~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.

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. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee

schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered during that service 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 schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. For purposes of this subparagraph, the term "service year" means the period from March 1 through the end of February of the following year.

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 subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her 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 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. If an insurer limits payment as authorized by subparagraph 1., 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. 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.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits or related relief under this section, 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 state that it is a "demand letter

under s. 627.736" and state the following with specificity:

1. The name of the insured on whose behalf ~~upon which~~ such benefits are being sought and, if the claimant is not the insured, the notice shall include~~, including~~ a copy of the assignment signed by the insured prior to the delivery of any such treatment, service, or accommodation, and giving rights to the claimant to seek benefits ~~if the claimant is not the insured~~.

2. The claim number and ~~or~~ policy number upon which such claim was originally submitted to the insurer by either the claimant or the insured.

3. Where ~~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 against the insurer. The notice shall be accompanied by an itemized statement identifying each treatment, service, or accommodation provided to the insured and shall specify for each such treatment, service, or accommodation on a line item basis as previously billed to the insurer~~; and an itemized statement specifying each exact amount,~~ the date of each treatment, service, or accommodation, the CPT code, ~~and~~ the amount charged, and the amount paid ~~type of benefit claimed to be due~~. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted, as applicable, shall be included with ~~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.

4. The identification of all line items that the claimant contends to be in dispute because of an insurer's nonpayment or underpayment, the legal or factual basis for the claimant's position that the insurer's underpayment payment or nonpayment is incorrect, the CPT code, and the amount that the claimant contends that the insurer is required to pay to fully resolve the dispute, including the specific amount of the statutory penalty, interest, and postage to be paid pursuant to paragraphs (d) and (e).

5. To the extent that an insurer has denied a claim on the basis that benefits are exhausted, the notice shall specify any treatment, service, or accommodation that the claimant contends to have been improperly paid, the amount of the asserted improper payment, and the amount that the insurer is required to pay to the claimant to resolve the dispute.

(c) If the claimant contends that the insured had an emergency medical condition, the notice shall be accompanied by documentation demonstrating that the insured to whom the treatment, service, or accommodation was provided sustained an

emergency medical condition. The documentation shall be from a provider identified in subparagraph (1)(a)1. or subparagraph (1)(a)2.

(d) ~~(c)~~ Each notice required by this subsection must comply with the requirements of paragraphs (b) and (c) and must be delivered to the insurer by United States certified or registered mail, return receipt requested. A notice that does not comply with the requirements of paragraphs (b) and (c) shall not trigger an insurer's obligations under paragraph (e). Such postal costs shall be reimbursed by the insurer if 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 the name and address of the designated person to whom notices must 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 is deemed the authorized representative to accept notice pursuant to this subsection if no other designation has been made.

(e) ~~(d)~~ If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice that complies with paragraphs (b) and (c) is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of

$250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is not payable in any subsequent action. For purposes of this 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 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 subsection.

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

(g) No action shall be filed or prosecuted by or on behalf

of a claimant seeking benefits or related relief against an insurer:

1. If a compliant notice is not sent to an insurer;

2. If the insurer issued full payment to the claimant in response to a notice within the timeframe prescribed by paragraph (e); or

3. Asserting a claim of nonpayment or underpayment of benefits not identified in the notice.

Any action filed or prosecuted by or on behalf of a claimant seeking benefits or related relief under this section in violation of this paragraph shall entitle an insurer to recover its reasonable legal fees, costs, and disbursements related to the defense of any such action against the claimant and its counsel.

Section 4. This act shall take effect July 1, 2020.