A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; providing a short title; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; authorizing the investigating officer to testify at trial or provide an affidavit concerning the content of the reports; amending s. 400.9905, F.S.; eliminating an exemption from certain regulations for clinics that receive more than a specified percentage of income from motor vehicle personal injury protection insurance policy benefits; authorizing rulemaking; amending s. 627.736, F.S.; limiting payments for services provided by chiropractic physicians and massage therapists; deleting provisions authorizing reimbursement to certain providers for services; deleting provisions relating to forms for certain providers; revising provisions relating to a prohibition on payment of benefits if the insured, claimant, medical provider, or attorney has committed certain acts; revising provisions relating to charges for treatment of injured persons; requiring claimants to submit to examinations under oath or sworn statements; providing procedures; requiring reimbursement to providers; providing that refusal or failure to appear for two medical examinations raises a rebuttable presumption that such refusal or failure was unreasonable;

providing restrictions on attorney fees; requiring attorney fees under no-fault provisions to be calculated without regard to any contingency risk multiplier; eliminating certain providers from provisions relating to the establishment of preferred providers; providing that if an insurer offers a preferred provider option, it must also offer a nonpreferred provider policy; authorizing an insurer to offer an actuarially appropriate premium discount to an insured who selects the preferred provider option; authorizing such policies to limit payment for nonemergency services in certain circumstances; authorizing an insurer to contract with another insurer for the right to use an existing preferred provider network to implement the preferred provider option; conforming cross-references; amending s. 627.7407, F.S.; repealing the Florida Motor Vehicle No-Fault Law on a date certain unless reviewed by the Legislature and reenacted prior to that date; requiring the Office of Insurance Regulation to perform a personal injury protection data call and publish results within a specified period; providing requirements for the data call; requiring each insurer transacting motor vehicle insurance to decrease rates through a "use and file" filing or make a full annual base rate filing within a specified period; providing for severability; providing an effective date.

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

Section 1. This act may be cited as the "Comprehensive Motor Vehicle Accountability Act."

Section 2. Subsection (1) of section 316.066, Florida Statutes, is amended to read:

316.066 Written reports of crashes.—

(1)(a) A Florida Traffic Crash Report must~~, Long Form is required to~~ be completed and submitted to the department within 10 days after ~~completing~~ an investigation is completed by the ~~every~~ law enforcement officer who in the regular course of duty investigates a motor vehicle crash ~~that:~~

~~1. Resulted in death or personal injury.~~

~~2. Involved a violation of s. 316.061(1) or s. 316.193~~.

(b) ~~In every crash for which a Florida Traffic Crash Report, Long Form is not required by this section, the law enforcement officer may complete a short-form crash report or provide a driver exchange-of-information form to be completed by each party involved in the crash.~~ The ~~short-form~~ report must include:

1. The date, time, and location of the crash.

2. A description of the vehicles involved.

3. The names and addresses of the parties involved, including all drivers and passengers, each clearly identified as being either a driver or a passenger and specifying the vehicle in which each person was a driver or passenger.

4. The names and addresses of witnesses.

5. The name, badge number, and law enforcement agency of

the officer investigating the crash.

6. The names of the insurance companies for the respective parties involved in the crash.

(c) Each party to the crash must provide the law enforcement officer with proof of insurance, which must be documented in the crash report. If a law enforcement officer submits a report on the crash, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

(d) The driver of a vehicle that was in any manner involved in a crash resulting in damage to any vehicle or other property in an amount of $500 or more which was not investigated by a law enforcement agency~~,~~ shall, within 10 days after the crash, submit a written report of the crash to the department. The entity receiving the report may require witnesses of the crash to render reports and may require any driver of a vehicle involved in a crash of which a written report must be made to file supplemental written reports if the original report is deemed insufficient by the receiving entity.

(e) The investigating law enforcement officer may testify at trial or provide a signed affidavit to confirm or supplement

the information included on the Florida Traffic Crash Report or driver exchange-of-information report ~~Short-form crash reports prepared by law enforcement shall be maintained by the law enforcement officer's agency~~.

Section 3. Subsection (4) of section 400.9905, Florida Statutes, is amended to read:

400.9905 Definitions.—

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; or entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; or

entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; or entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or

indirectly, with an entity licensed or registered by the state pursuant to chapter 395; or entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees not less than two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more

of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or

chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) Orthotic or prosthetic clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

Notwithstanding these exemptions, any legal entity deriving more than 30 percent of its gross income, as measured each calendar year, beginning January 1, 2013, from motor vehicle personal injury protection insurance policy benefits is a clinic as defined by this subsection and does not qualify for an exemption. The agency may prescribe rules by which it can collect revenue information from such entities and require the reporting thereof on an annual basis.

Section 4. Subsection (1), paragraph (h) of subsection (4), paragraph (a) of subsection (5), subsection (6), paragraph (b) of subsection (7), and subsections (8) and (9) of section 627.736, Florida Statutes, are amended 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 must ~~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)(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)1. Medical benefits.—Eighty percent of ~~all reasonable~~ expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and for medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide reimbursement only for such services and care that are lawfully provided, 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.

2. Chiropractic and massage.—Reimbursement for services provided by chiropractic physicians licensed under chapter 460 and massage therapists licensed under chapter 480, limited to the lesser of 24 treatments or to services rendered within 12 weeks after the date of the initial chiropractic or massage therapy treatment, whichever comes first. However, an insurer may authorize additional chiropractic or massage therapy services. ~~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 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 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 ss. 400.990-400.995 that is:~~

~~a. 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 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 paragraph ~~provision~~ shall be paid 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 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 an insurer may not ~~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 violates ~~shall be deemed to have violated~~ part IX of chapter 626, which constitutes ~~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 is ~~shall be~~ subject to the penalties authorized ~~afforded~~ in such part, as well as those authorized ~~which may be afforded~~ elsewhere in the insurance code.

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and 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. 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, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(h) Benefits shall not be due or payable to or on the behalf of an insured, claimant, medical provider, or attorney ~~person~~ if the insured, claimant, medical provider, or attorney has:

1. Submitted a false or misleading statement, document, record, or bill;

2. Submitted false or misleading 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 personal injury protection 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 a violation by another claimant ~~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 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 prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph~~.

(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 an ~~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. When determining ~~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 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 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 ~~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, including durable medical equipment, care, and services rendered by a clinical laboratory, 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, or if the care and services are rendered in an ambulatory surgical center, 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 was rendered and for the area in which such services were rendered, 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.

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 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.

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.

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

(a) An insurer may require a claimant to submit to an

examination under oath or sworn statement. The insurer is not liable for benefits under the no-fault law if the claimant fails to fully and truthfully answer all questions relating to the claim for benefits or violates any provision of paragraph (4)(h).

1. The insurer may conduct the examination outside the presence of any other person seeking benefits or reimbursement.

2. If an insurer requests an examination of a claimant that is in a hospital, clinic, or other medical institution, such claimant shall produce the persons with the most knowledge relating to the issues set forth by the insurer in the notice of examination.

3. The claimant must provide the insurer at the examination with all documents, papers, receipts, invoices, bills, records, or other tangible items requested by the insurer that are related to the claim.

4. The examination may be recorded by audio, video, or court reporter or any combination thereof. The claimant may record the examination at the claimant's expense.

5. The claimant may have an attorney present at the examination at the claimant's expense.

6. An insurer must coordinate with the claimant to ensure an appropriate time and location for the examination. A claimant’s failure to agree to attend an examination after an insurer presents two documented offers of a reasonable time and location allows the insurer to suspend benefits, until such time that the claimant agrees to submit to, and does actually submit to, an examination.

7. If the claimant is a medical provider that is not the insured, the insurer must pay the claimant reasonable compensation for attending the examination under oath. Such compensation shall be based upon a good faith estimate of the time required to conduct the examinations under oath. If additional time is necessary for completion of the examination under oath, the insurer must provide compensation to the medical provider for the time that exceeds the good faith estimate within 15 days after the examination under oath so long as the medical provider completes the examination. The medical provider may have an attorney present at the examination under oath at his or her own expense.

(b) ~~(a)~~ Every employer shall, if a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, furnish forthwith, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(c) ~~(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.

(d) ~~(c)~~ In the event of any dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction 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 it shall specify the time, place, manner, conditions, and scope of the discovery. Such 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.

(e) ~~(d)~~ The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(f) ~~(e)~~ Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

(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 or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. Refusal or failure to appear for two examinations raises a rebuttable presumption that such refusal or failure was unreasonable.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY ~~ATTORNEY'S~~ FEES.—

(a) 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 applies ~~shall apply~~, except as provided in paragraphs (b) and (c) and subsections (10) and (15) and except that any attorney fees recovered are limited to the

lesser of $200 per billable hour or:

1. For any disputed amount of less than $500, 15 times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $5,000.

2. For any disputed amount of $500 or more and less than $5,000, 10 times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $10,000.

3. For any disputed amount of $5,000 or more and up to $10,000, 5 times any disputed amount recovered by the attorney under ss. 627.730-627.7405, limited to a total of $15,000.

Fees incurred in litigating or quantifying the amount of fees due to the prevailing party under ss. 627.730-627.7405 are not recoverable.

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

(c) Attorney fees in a class action under ss. 627.730-627.7405 are limited to the lesser of $50,000 or 3 times the total of any disputed amount recovered in the class action proceeding.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~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 466 ~~463~~.

(a) The insurer may provide an option to an insured to use

a preferred provider at the time of purchase of the policy for personal injury protection benefits~~,~~ if the requirements of this subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy ~~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~~.

(b) If the insured elects the ~~to use a provider who is a~~ preferred provider option, 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. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the policy may provide that charges for nonemergency services provided within this state are payable only if performed by members of the preferred provider network unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services ~~If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy~~.

(c) 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 purchasing ~~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. The insurer may contract with another insurer for the right to use an existing preferred provider network to implement the preferred provider option. Any other arrangement is subject to the approval of the Office of Insurance Regulation.

Section 5. Subsection (9) is added to section 627.7407, Florida Statutes, to read:

627.7407 Application of the Florida Motor Vehicle No-Fault Law.—

(9) Sections 627.730-627.7405, the Florida Motor Vehicle No-Fault Law, and this section are repealed effective July 1, 2015, unless reviewed by the Legislature and reenacted prior to that date.

Section 6. The Office of Insurance Regulation shall perform a personal injury protection data call, with results published not later than 24 months after the effective date of this act. Elements of the data call shall include, but are not limited to, the number of personal injury protection claims filed, the number of independent medical examinations requested and completed, the number of examinations under oath requested and completed, and the number of denied claims.

Section 7. Notwithstanding section 627.0645, Florida Statutes, each insurer transacting motor vehicle insurance must, within 18 months after the effective date of this act, decrease rates through a "use and file" filing or make a full annual base

rate filing with the Office of Insurance Regulation. An insurer may not be exempted from this requirement by certification of an existing rate level that is actuarially sound and not inadequate pursuant to s. 627.0645(3)(b), Florida Statutes.

Section 8. 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 9. This act shall take effect July 1, 2012.