A bill to be entitled

An act relating to motor vehicle insurance; amending s. 627.311, F.S.; authorizing a joint underwriting plan and the Florida Automobile Joint Underwriting Association to cancel certain insurance policies within a specified period under certain circumstances; prohibiting an insured from canceling certain insurance policies within a specified period; providing exceptions; amending s. 627.736, F.S.; revising the period during which the applicable fee schedule or payment limitation under Medicare applies with respect to certain personal injury protection insurance coverage; defining "service year"; deleting an obsolete date; amending s. 627.744, F.S.; revising the exemption from the preinsurance inspection requirements for private passenger motor vehicles to include certain leased vehicles; revising the list of documents that an insurer may require for purposes of the exemption; prohibiting the physical damage coverage on a motor vehicle from being suspended during the term of a policy due to the insurer's option not to require certain documents; authorizing a payment of a claim to be conditioned if the insurer requires a document under certain circumstances; providing an effective date.

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

Section 1. Paragraph (m) is added to subsection (3) of section 627.311, Florida Statutes, to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.—

(3) The office may, after consultation with insurers licensed to write automobile insurance in this state, approve a joint underwriting plan for purposes of equitable apportionment or sharing among insurers of automobile liability insurance and other motor vehicle insurance, as an alternate to the plan required in s. 627.351(1). All insurers authorized to write automobile insurance in this state shall subscribe to the plan and participate therein. The plan shall be subject to continuous review by the office which may at any time disapprove the entire plan or any part thereof if it determines that conditions have changed since prior approval and that in view of the purposes of the plan changes are warranted. Any disapproval by the office shall be subject to the provisions of chapter 120. The Florida Automobile Joint Underwriting Association is created under the plan. The plan and the association:

(m) May cancel personal lines or commercial policies issued by the plan within the first 60 days after the effective date of the policy or binder for nonpayment of premium if the reason for cancellation is the issuance of a check for the premium that is dishonored for any reason or any other type of

premium payment that is rejected or deemed invalid. An insured may not cancel a policy or binder within the first 90 days, or within a lesser period as required by the plan, after the effective date of the policy or binder, except:

1. Upon total destruction of the insured motor vehicle;

2. Upon transfer of ownership of the insured motor vehicle; or

3. After purchase of another policy or binder covering the motor vehicle that was covered under the policy being canceled.

Section 2. Paragraph (a) of subsection (5) of section 627.736, Florida Statutes, is 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, 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, 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 ~~throughout the remainder of~~ 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. ~~Effective July 1, 2012,~~ 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.

Section 3. Paragraphs (a) and (b) of subsection (2) of section 627.744, Florida Statutes, are amended to read:

627.744 Required preinsurance inspection of private passenger motor vehicles.—

(2) This section does not apply:

(a) To a policy for a policyholder who has been insured

for 2 years or longer, without interruption, under a private passenger motor vehicle policy that ~~which~~ provides physical damage coverage for any vehicle, if the agent of the insurer verifies the previous coverage.

(b) To a new, unused motor vehicle purchased or leased from a licensed motor vehicle dealer or leasing company.~~, if~~ The insurer may require ~~is provided with~~:

1. A bill of sale, ~~or~~ buyer's order, or lease agreement that ~~which~~ contains a full description of the motor vehicle~~, including all options and accessories~~; or

2. A copy of the title or registration that ~~which~~ establishes transfer of ownership from the dealer or leasing company to the customer and a copy of the window sticker ~~or the dealer invoice showing the itemized options and equipment and the total retail price of the vehicle~~.

For the purposes of this paragraph, the physical damage coverage on the motor vehicle may not be suspended during the term of the policy due to the applicant's failure to provide or the insurer's option not to require the required documents. However, if the insurer requires a document under this paragraph at the time the policy is issued, payment of a claim may be ~~is~~ conditioned upon the receipt by the insurer of the required documents, and no physical damage loss occurring after the effective date of the coverage is payable until the documents are provided to the insurer.

Section 4. This act shall take effect July 1, 2015.