SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1202

SPONSOR: Appropriations Committee, Banking and Insurance Committee and Senator Alexander

SUBJECT: Motor Vehicle Insurance

DATE: April 23, 2003 REVISED: ________ ________ ________ ________

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			AGG	Withdrawn
3.	Eisenbart/Herring	Coburn	AP	Favorable/CS
4.			RC	
5.				
6.				

I. Summary:

Committee Substitute for Committee Substitute for SB 1202 creates the "Motor Vehicle Insurance Affordability Reform Act" which implements the majority of the recommendations[1] contained in the Final Report of the Senate Select Committee on Automobile Insurance/PIP Reform issued on March 3, 2003, and other revisions[2] to the PIP (personal injury protection) automobile insurance laws. In summary, the bill does the following:

Criminal Penalties for PIP Fraud

Creates new crimes for soliciting accident victims, intentionally causing motor vehicle accidents, disclosing confidential vehicle accident reports, presenting false or fraudulent motor vehicle insurance cards, and specified fraudulent actions by insurers and providers; increases penalties for soliciting accident victims and presenting false or fraudulent insurance applications; provides

---

[1] Two Select Committee recommendations are not contained in this bill: requiring minimum mandatory sentences for insurance fraud and allowing insurers and insureds to sue a person who committed insurance fraud, patient brokering, or kickbacks associated with PIP claims. However, the bill does have three provisions which are similar, but more specific, than the Select Committee recommendations: minimum mandatory penalties for intentionally causing motor vehicle accidents and soliciting accident victims during the 60-day period accident reports are confidential; allowing insurers and insureds to sue any person or business entity to recover payments for services later determined to have been unlawfully rendered; and allowing insurers to recover benefits paid prior to the discovery of insurance fraud from the person who actually committed the fraud. (An insurer may also obtain costs and attorney's fees in any action in which it prevails.)

[2] There are some PIP issues contained in this bill on which the members of the Select Committee did not reach agreement because there was not sufficient time for the members to thoroughly debate these issues in order to reach a general consensus. These matters pertain to utilizing voluntary insurance alternative dispute resolution and peer review processes, establishing guidelines for attorney's fees, providing for application of contingency risk multipliers in specified circumstances, applying the offer of judgment provision to PIP issues, providing for specified fraudulent actions by insurers and providers, and other provisions.

minimum mandatory penalties for intentionally causing motor vehicle accidents and soliciting accident victims during the 60-day period accident reports are confidential; increases the ranking of solicitation crimes and certain motor vehicle insurance fraud offenses under the Offense Ranking Chart law; and provides funding for insurer Special Investigation Units, the Division of Insurance Fraud within the Department of Financial Services, and the Office of Statewide Prosecution for the prevention, investigation, and prosecution of motor vehicle insurance fraud by increasing specified agent fees.

Regulation of Health Care Clinics

Transfers health care clinic regulation from the Department of Health (DOH) to the Agency for Health Care Administration (AHCA) to be funded by license application fees up to $2,000, every 2 years; strengthens clinic regulation by requiring clinics to be licensed rather than registered; authorizes AHCA to conduct clinic inspections and requires Level 2 background screenings under ch. 435, F.S.,[3] of clinic applicants who own or control, directly or indirectly, 5 percent or more of interest in the clinic, and other licensed medical employees; prohibits an applicant that has committed a Level 2 crime (including violations relating to insurance fraud) within the past 5 years from obtaining a clinic license or work as a licensed medical provider, medical director, or clinical director; provides that civil rights must be restored prior to obtaining a license; requires clinics to have a fixed location (not be mobile); mandates clinics to allow AHCA complete access to premises and records; authorizes the agency to impose administrative fines or seek corrective action from clinic owners or directors under specified circumstances; requires MRI clinics to become accredited by specified national organizations within 1 year of licensure; and provides penalties.

Authorizes AHCA to institute injunctive proceedings and agency actions under specified circumstances. Provides for new crimes and penalties associated with operating an unlicensed clinic and provides that providers, who are aware of the operation of an unlicensed clinic but fail to report such clinic, be reported to an appropriate licensing board.

Medical Fee Schedule, Unnecessary Diagnostic Tests, Independent Medical Examinations

Limits medical fees for treatments, including the provision of magnetic resonance imaging (MRI) services, under PIP to 200 percent of the Medicare Part B participating physicians fee schedule; provides for certain diagnostic tests to be under the workers' compensation fee schedule; exempts hospitals from certain requirements; authorizes the Department of Health, in consultation with the appropriate medical boards, to establish a list of diagnostic tests that are not medically necessary, and therefore not compensable; and clarifies that insurers and their insureds are not required to pay bills that do not meet a fee schedule or other provisions.

Requires that insurers or providers may not improperly miscode services; prohibits insurers or their employees from improperly requiring physicians to materially change IME reports, provided that this does not preclude the insurer from notifying the physician of errors of fact in

[3] Level 2 standards for screening are set forth in ch. 435, F.S., which provides that persons in positions of trust or responsibility must undergo security background investigations that include fingerprinting by FDLE. Further, persons subject to such screenings must not have committed certain specified crimes under that section.

the report based on information in the claim file; provides penalties; mandates physicians who prepare IME reports to maintain such reports and applicable payment records for at least 3 years.

Provides for a PIP financial incentive to consumers to report improper billing by providers; provides that if medical treatments are rendered out of state, then the reimbursement amount is set for the area where the insured resides; and provides that an insured and insurer may have a civil cause of action against any person to recover payments for services later determined to have not been lawfully rendered.

PIP Billing Provisions

Requires that the written notice of medical benefits, furnished to insurers by providers, must meet specified billing and coding provisions before insurers are required to submit payment. Provides that the Financial Services Commission shall, by rule, develop a disclosure and acknowledgment form which allows an insured, or guardian, to attest to specified service provisions, and that such form must be signed by the insured, or guardian, and provider, attesting to the fact that services were rendered. Provides that insurers may not systematically downcode with the intent to deny reimbursement otherwise due.

Increased PIP Benefits by Financial Services Commission

Provides that if the Financial Services Commission determines that cost savings under PIP have been realized due to the provisions in this act, prior reforms, or other factors, then the Commission may increase the minimum $10,000 benefit coverage requirement. However, in establishing the amount of the increase, the Commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized by the $10,000 PIP coverage.

Demand Letter, Medical Peer Review, and Alternative Dispute Resolution Process

Expands the current presuit demand letter provision to be applicable to all PIP disputes and increases the time for insurers to respond to the demand letter from 7 business days to 15 calendar days. Provides that parties in a PIP dispute may utilize the medical peer review (MPR) mechanism for issues relating to medical necessity, correct coding, the reasonableness as to the amount charged, and matters related to coverage issues. Parties may further use the alternative dispute resolution (ADR) process for issues not covered under the MPR process. Both procedures are intended to expedite medical and payment disputes between insureds (or providers) and insurers and the option to use either the MPR or ADR, or both, affects the application of attorney's fees and other costs.

Appropriation

The bill provides for an appropriation of $2.5 million from the Health Care Trust Fund, and 51 FTE's authorized to AHCA to implement the provisions of the bill.

This bill substantially amends the following sections of the Florida Statutes: 119.105, 316.066, 456.0375, 456.072, 626.7451, 627.732, 627.736, 627.739. 768.79, 817.234, 817.236, and 921.0022.

This bill creates the following sections of the Florida Statutes: 400.901, 400.903, 400.905, 400.907, 400.909, 400.911, 400.913, 400.915, 400.917, 400.919, 400.921, and 817.2361. This bill repeals s. 456.0375, Florida Statutes, effective March 1, 2004.

II. Present Situation:

Current Automobile Insurance Requirements

The Legislature enacted Florida's "no-fault" insurance provisions in 1971.[4] Under the Florida Motor Vehicle No-Fault law, every owner of a four-wheeled motor vehicle registered in Florida is required to maintain $10,000 of no-fault personal injury protection ("PIP") insurance[5] and $10,000 in property damage ("PD") insurance.

Subject to co-payments and other restrictions, PIP insurance provides compensation for bodily injuries to the insured driver and passengers *regardless of who is at fault in an accident.* This coverage also provides the policyholder with immunity from liability for economic damages up to the policy limits and for non-economic damages (pain and suffering) for most injuries. However, the immunity does not extend to injuries consisting of: (1) significant and permanent loss of an important bodily function; (2) permanent injury within a reasonable degree of medical probability (other than scarring or disfigurement); (3) significant and permanent scarring or disfigurement; or (4) death. This is known as the "verbal threshold." In summary, a plaintiff must suffer a permanent injury in order to seek pain and suffering damages against a motorist with PIP coverage.

Persons required to have PIP must also obtain property damage liability coverage. Property damage liability insurance must provide a minimum per-crash coverage of $10,000 for property damage, or $30,000 for combined property damage and bodily injury liability. Property damage to a vehicle is not covered under the no-fault law; that is, the person who negligently causes the property damage is liable, which is covered by PD liability.

Benefits Available

Personal injury protection covers the named insured, relatives residing in the same household, passengers, persons driving the vehicle with the insured's permission, and persons struck by the motor vehicle while not an occupant of a self-propelled vehicle. With respect to injuries sustained in a motor vehicle accident, regardless of who is at fault, a vehicle owner's PIP coverage will pay 80 percent of medical costs, 60 percent of lost income, and a $5,000 per-person death benefit, up to a limit of $10,000.

---

[4] Ch. 71-252, L.O.F. The law became effective January 1, 1972.
[5] Sections 627.730-627.7405, F.S.

Financial Responsibility Law

The Florida "Financial Responsibility Law" (ch. 324, F.S.), requires drivers to demonstrate their ability to respond to damages for bodily injury caused in an accident. This law requires a minimum level of bodily injury (BI) liability insurance, or other allowable form of security, but only *after* a driver has been involved in an accident or convicted of certain serious traffic offenses. Such proof of BI coverage is *not* required as a condition of registering a vehicle, as required for PIP and PD, unless the Financial Responsibility law has been triggered by a prior accident or conviction. The minimum amounts of liability coverage required are $10,000 in the event of bodily injury to, or death of, one person; $20,000 in the event of injury to two or more persons; and $10,000 in the event of injury to property of others; or $30,000 combined single limit. If the owner or operator of the vehicle was not financially responsible at the time of the accident, that individual's driver's license is suspended as well as the registration of the owner of the vehicle. An individual can comply with the Financial Responsibility law in several ways: liability insurance, surety bond, deposit of cash or securities, or self-insurance.

2003 Senate Select Committee on Automobile Insurance/PIP Reform

On December 5, 2002, Senate President King created the Select Committee on Automobile Insurance/PIP Reform to address the problems with PIP insurance which range from fraud and abuse to the soaring costs that exist within this automobile insurance market. The Select Committee met five times during January, February, and March and heard testimony and received information from a wide variety of interests: insurance companies, trial lawyers, fraud investigators, medical consultants, agency regulators, and representatives from the hospital, chiropractic, medical, trial, and insurance associations.

The Select Committee members agreed that the reforms made in 1998 and 2001,[6] did not go far enough in attacking the problems of fraud and abuse occurring within the PIP system. There was also a consensus among the members that the goals behind the Legislature's adoption of the PIP no-fault law in 1971 had been significantly compromised. After hearing the testimony, all the members of the Select Committee agreed that:

---

[6] During both the 1998 and 2001sessions (ch. 98-27; ch. 2001-271; and ch. 2001-163, L.O.F.), the Legislature passed automobile insurance reform legislation which included the following:
• Requiring health care providers to submit statements and bills for medical services in a timely fashion on specified forms with procedural codes.
• Revising geographical requirements for independent medical examinations (IMEs) of claimants.
• Requiring health care clinics to register with the Department of Health and to have a licensed physician as medical director.
• Adopting a medical fee schedule for specified procedures.
• Curtailing the activities of "brokers," who improperly received compensation from insurers or insureds for the use of medical equipment. The improper activities of brokers were defined, and charges for services rendered by such persons were made noncompensable and unenforceable.
• Requiring, as a condition precedent to filing actions for non-payment of PIP claims, that insurers receive a 7-day notice of the intent to litigate via a "demand letter."
• Elevating the ranking of specific insurance fraud crimes under the Offense Severity Ranking Chart law and increasing penalties for other insurance related crimes.
• Limiting access to vehicle accident (crash) reports so that illegal solicitation activity could be curtailed.
• Creating a civil cause of action to allow insurers to sue a person who, in connection with a PIP claim, is found guilty of, or plead guilty or nolo contendere to, regardless of adjudication of guilt, insurance fraud, patient brokering, or kickbacks.

- Fraud continues to permeate the PIP insurance market and constitutes a serious problem in Florida.

- According to the Division of Insurance Fraud, fraud adds as much as $240 to the average Florida family's auto insurance premiums, annually.

- Over the past 5 years, the average Florida PIP claim rose 33 percent (from $4,287 to $5,687), and PIP and BI (bodily injury liability) loss costs (amount of premium needed per insured vehicle to pay claims) have escalated by 35 percent and 18 percent, respectively.

- As costs escalate, as many as 22 percent of Florida drivers choose not to carry PIP insurance, according to the Department of Highway Safety and Motor Vehicles.

- Florida is the 4th highest in terms of both PIP and BI loss costs among the 13 states which have no-fault (PIP) laws.

- Florida's PIP coverage benefit of $10,000 has not kept up with inflation and is worth $3,730 in today's dollars based on the Consumer Price Index. Of the other no-fault states, six states provide higher PIP coverage benefits than Florida, two states offer the same coverage, and four states require less coverage benefits than Florida.

- Medically inappropriate diagnostic testing, inflated charges, and over-utilization of treatments by certain medical providers greatly impact PIP and BI insurance costs.

- In certain cases, both insurers and providers are improperly and systematically changing codes which apply to the provision of medical services. Furthermore, in some instances, insurance companies improperly request physicians preparing independent medical examination (IMEs) reports to change or modify the report.

- According to representatives with the Department of Health, 2,404 health care clinics are currently registered with the Department, however, the agency lacks the statutory authority or the necessary resources to perform adequate background investigations of clinic owners or to investigate and inspect clinics.

As noted above, the great majority of the recommendations of the Select Committee are contained in this bill. However, some PIP were not resolved by the members of the Select Committee, or were not otherwise considered, because the members did not have sufficient time to thoroughly debate the issues in order to reach a general consensus. These matters pertain to utilizing voluntary medical peer review and alternative dispute resolution mechanisms which will impact application of attorney's fees and other costs, specifying application of contingency risk multipliers in certain instances, applying the offer of judgment provision to PIP issues, providing for specified fraudulent actions by insurers and providers, and other provisions.

Current PIP Provisions

Under present law, PIP insurance benefits paid pursuant to s. 627.736, F.S., are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of the covered loss and the amount of such loss. If a written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer.

Health care providers may charge "only a reasonable amount for services and supplies rendered" and in no event may a charge be "in excess of the amount the person (provider) or institution customarily charges for like services or supplies in cases involving no insurance." Providers are not subject to a fee schedule for charges for services under the PIP law. However, there are several exceptions, in that certain diagnostic tests are currently subject to the workers' compensation fee schedule under s. 440.13, F.S. These tests include medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing. Nerve conduction testing performed by certified providers may be billed at 200 percent of Medicare Part B. Charges for magnetic resonance imaging (MRI) services are limited to 175 percent of Medicare Part B, but may be billed at 200 percent of Medicare Part B, if offered at facilities accredited by specified organizations.

Other states have adopted some type of PIP medical fee schedule to address cost containment of medical services. For example, Pennsylvania limits PIP fees to 110 percent of Medicare reimbursement while in New Jersey, the Insurance Department bases fees on the type of service provided and such fees must incorporate the reasonable and prevailing fees of 75 percent of the practitioners within the region. If there are fewer than 50 specialists in the region, the fee schedule incorporates the reasonable and prevailing fees of the specialist providers on a statewide basis. Hawaii's fee schedule for medical services must not exceed 110 percent of the participating physician fees under Medicare. In Hawaii, the reimbursement to chiropractors is limited to an aggregated certain dollar amount per visit along with a cap on the number of visits. In Utah, the Insurance Department has to conduct a study every other year to determine the reasonable value of medical expenses. Under workers' compensation laws, the majority of states (41) have adopted some type of fee schedule to limit medical costs. The types of fee schedules include Medicare, Medicaid, and other schedules.

Organizations that accredit MRI facilities may charge fees in the thousands of dollars and take many months to several years to review the facility before awarding accreditation. According to representatives with AHCA, one such organization charges a minimum amount of approximately $8,500 per facility location, takes from six to eight months for the facility to be accredited, and requires reaccreditation every three years. To become accredited, facilities must comply with applicable health care standards for delivery of services and patient care, comply with state and federal laws and regulations, be licensed in the state in which they are located, provide health care services under the direction of licensed providers, and allow inspection of the facility and its records by the accrediting organization.

Currently, medical utilization guidelines for PIP services or treatments exist, and no guidelines for medical tests which are deemed to be unnecessary and therefore noncompensable, exist.

Under present law, insurers may negotiate and enter into contracts with licensed health care providers to offer their insureds preferred provider policies (PPOs) under s. 627.736(10), F.S. Such policies allow an insured to pay a lower premium if the insured uses a preferred health care provider (who has contracted with the insurer or has contracted with the insurer through an intermediary) under a PPO plan when the insured is involved in a motor vehicle accident. As an alternative, several large insurers have provided to their insureds at the point of claim (after an accident), a list of health care providers with whom the insurer has contracted, either directly or indirectly, for reduced rates. The insurers encourage insureds to use such providers by telling the insureds that a greater level of benefits may be obtained for the $10,000 PIP limits. However, some of these providers are litigating this issue with the PIP insurers. These providers allege that the PIP law controls their PPO contract with insurers and allows them to charge any reasonable rate for their services (and not the PPO rate). Representatives with one large insurer stated that the majority of county courts have sided with providers and not the insurers on this issue. However, representatives with this company state that they have a letter from the former General Counsel with the Department of Insurance who approved the insurer PPO arrangement in 1999.

The current demand letter provision requires that a written notice of intent to initiate litigation be provided to the insurer as a condition precedent to filing suit for an unpaid claim. The pre-suit notice cannot be sent until the claim is overdue and must state with specificity certain information to be included in the notice, including the name of the insured, claim number, and the medical provider who rendered treatment, along with an itemized statement listing the exact amount, dates of treatment, service, and type of benefits claimed to be due. If the claim, along with applicable interest, is paid within 7 business days, the claimant is prohibited from bringing an action against the insurer for nonpayment or late payment of a claim. The statute of limitations is tolled for a period of 15 days by the mailing of the notice. Any insurer who engages in a general business practice of not paying valid claims until receipt of the notice, commits an unfair trade practice under the Insurance Code.

Attorney's Fees (Lodestar and Contingency Risk Multipliers)

Under present law, insurers are required to pay attorney's fees under s. 627.428, F.S., if they lose in court to insureds or to beneficiaries under an insurance policy or contract. However, if insurers prevail in court, their fees are not paid by the losing side. This section is known as the "one-way attorney's fee" provision. Currently, attorney's fees are calculated according to the application of two common law-created provisions: Lodestar and contingency risk multipliers.[7] A contingency risk multiplier is a number ranging from 1.0 to 2.5 that may be applied by the court when it awards attorney's fees. It may be applied once the court initially determines the Lodestar figure (which is basically the number of hours expended by an attorney on a particular case, multiplied by an hourly rate). The contingency risk multiplier may be applied to the Lodestar figure by multiplying the risk multiplier number (ranging from 1.0 to 2.5) times the Lodestar figure to determine the attorney's ultimate fee.

The Lodestar factors utilized by a court in determining a reasonable attorney's fee are enunciated in the Florida Bar Code of Professional Responsibility under Rule 4-1.5. There are eight factors

[7] See *Standard Quaranty Insurance Co. v. Quanstrom,* 555 So.2d 828. (Fla. 1990).

listed which include the nature and length of the professional relationship with the client; the time and labor required; the novelty, complexity, and difficulty of the questions involved, and the legal skill needed to perform the legal service in the case; the significance of, or amount, involved in the subject manner of the representation; the fee customarily charged in the locality; etc.

After the Lodestar is calculated, the court considers three factors to determine whether the risk multiplier is necessary: 1) whether the relevant market requires a contingency fee multiplier to obtain competent counsel; 2) whether the attorney was able to mitigate the risk of nonpayment in any way; and 3) the amount involved in the case, the result obtained, and the type of fee arrangement between the attorney and the client. Other factors are utilized by the court which involve consideration of the chances of success at the outset of trial: 1) if success was more likely than not at the outset, the court may apply a multiplier of 1 to 1.5; 2) if success was approximately even at the outset of trial, the trial judge may apply a multiplier of 1.5 to 2.0; 3) if success was unlikely at the outset, a multiplier from 2.0 to 2.5 may be applied.

Other provisions of current law affected by this bill are summarized below.

III. Effect of Proposed Changes:

The bill addresses the rising cost of motor vehicle insurance as well as the problems of fraud and abuse which affect Florida's no-fault insurance system. It addresses the following issues: strengthens anti-fraud provisions and health care clinic regulation; provides funding for insurer special investigation units, the Division of Insurance Fraud, and the Office of Statewide Prosecution to investigate and prosecute motor vehicle insurance fraud; establishes medical fee schedules; provides for billing and coding requirements; sets up an expedited peer review process for medical issues and an expedited alternative dispute resolution process for other issues to encourage settlements and decrease litigation; and provides for other reforms so that cost-savings may be realized for all drivers in this state.

Section 1. Declares that the law be entitled the "Florida Motor Vehicle Insurance Affordability Reform Act" and makes legislative findings. It declares that the principle underlying the basis of the no-fault or personal injury protection (PIP) insurance system is that of a trade-off of one benefit for another, which is providing medical and other benefits in return for a limitation on the right to sue for non-serious injuries. The PIP law has provided valuable benefits to consumers over the years in the form of medical payments, lost wages, replacement services, funeral payments, and other benefits, without regard to fault.

The bill makes Legislative findings that the goals behind the adoption of the original no-fault law which were to quickly and efficiently compensate accident victims regardless of fault, reduce the volume of lawsuits by eliminating minor injuries from the tort system, and reduce overall motor vehicle insurance costs, have been significantly compromised due to fraud and abuse which have permeated the PIP insurance market. The bill finds that such fraud and abuse, other than in the hospital setting, has increased premiums for consumers and must be uncovered and prosecuted. The problem of inappropriate medical treatment and inflated claims for PIP have generally not occurred in the hospital setting.

A further finding is that the no-fault system has been weakened in part due to certain insurers not adequately or timely compensating injured accident victims or health care providers. Also, the PIP system has become increasingly litigious with attorneys obtaining large fees by litigating, in certain instances, over relatively small amounts that are in dispute. Therefore, there is an overwhelming public necessity to expand the provisions of the demand letter, establish expedited peer review and alternative dispute resolution processes to minimize litigation, reduce costs and fees, and encourage settlements.

The Legislature finds it is a matter of great public importance that, in order to provide a healthy and competitive automobile insurance market, consumers be able to obtain affordable coverage, insurers be entitled to earn an adequate rate of return, and providers of services be compensated fairly. Further, to protect the public's health, safety, and welfare, it is necessary to enact the provisions of this bill to prevent PIP fraud and abuse and curb escalating medical, legal, and other related costs. The Legislature finds that the provisions of this act are the least restrictive actions necessary to achieve these goals. The stated purpose of this act is to restore the health of the PIP insurance market by addressing these issues, preserve the no-fault system and thus realize cost-savings for all citizens.

Section 2. Amends s. 119.105, F.S., to prohibit persons who legally obtain exempt or confidential PIP accident (police) reports, during the 60-day period such reports are confidential, from disclosing information in the report to a third party for purposes of commercially soliciting accident victims. Clarifies that this section does not prohibit publication of information to the general public by news media legally entitled to possess such reports. Under current law, use of police reports for commercial solicitation is a third-degree felony and therefore this new prohibition will also be a third-degree felony.

Section 3. Amends s. 316.066, F.S., to require persons who legally obtain exempt or confidential PIP accident (crash) reports, during the 60-day period such reports are confidential, to present a valid driver's license or other photographic identification and file a sworn statement stating the report will not be used for commercially soliciting victims or disclosed to third parties. It adds an exception to the above requirements for third-party vendors who furnish crash reports solely to insurers for adjustment, claims investigations, and underwriting purposes. Such vendors must be approved by the Division of Insurance Fraud (DIF) within the Department of Financial Services and contractually agree (with DIF) that the information contained in crash reports will not be used for commercial solicitation. Provides that it is a third degree felony for vendors to knowingly use confidential information in violation of their contractual agreement with the division.

The bill provides that this section does not prevent the publication of news to the general public by any legitimate media entitled to access the confidential reports. It further provides that a law enforcement officer, as defined in s. 943.10(1), F.S., may enforce this provision. The provision mandates that it is a third-degree felony for any person to knowingly use confidential information in violation of a filed written sworn statement.

Under current law, crash reports are confidential for 60 days after the date the report is filed and are available to specified persons, e.g., parties involved in the crash, their insurers and legal representatives, prosecutors and law enforcement, and the media. It is a third-degree felony for

any employee of a state or local agency to disclose confidential reports and for persons, knowing that they are not entitled to such reports, to obtain the confidential report.

Section 4. Effective October 1, 2003, this provision creates part XIII of ch. 400, F.S., consisting of ss. 400.901-400.921, F.S., to be entitled the "Health Care Clinic Act." This part essentially transfers health care clinic regulation currently administered by the Department of Health (DOH) to the Agency for Health Care Administration (AHCA) to be funded by license application fees up to $2,000, every 2 years. The agency is required to adjust the license fee annually by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase. The bill provides legislative findings that the regulation of health care clinics must be strengthened to prevent significant cost and harm to consumers and that its purpose is to license, establish, and enforce basic standards for health care clinics with oversight by AHCA.

It requires clinics to be licensed rather than registered, which is current law under s. 456.0375, F.S. (Note: this section is repealed effective March 1, 2004, under Section 17, below.) It defines the term "clinic" to mean an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services. Each clinic must become licensed by AHCA, with the following exceptions:

(a) Entities licensed or registered under chapters 390 (abortion), 394 (mental health), 395 (hospitals), 400 (nursing homes), 463 (optometry), 465 (pharmacy), 466 (dental), 478 (electrolysis), 480 (massage), or 484 (optical), or 651 (continuing care); entities that own, are owned, or are under common ownership, directly or indirectly, with such licensed or registered entities, or are exempt from federal taxation under the Tax Code; and any community college or university clinic; or

(b) Sole proprietorships, group practices, partnerships, or corporations that provide health care services by licensed health care practitioners under chs. 457 (acupuncture), 462 (naturopathy), 463, (optometry), 466 (dentists), 467 (midwifery), 484 (optical), 486 (physical therapy), 490 (psychological services), 491 (clinical counseling), F.S., or parts I, (audiology/speech-language pathology), III (occupational therapy), X (dietetics), XIII (athletic trainers), or XIV (orthotics, prosthetics, and pedorthics) of ch. 468, F.S., are wholly owned by a licensed health care practitioner, or a licensed practitioner and spouse, parent, or child of a licensed health care practitioner, so long as one of the owners who is a licensed practitioner is supervising the services performed therein and is legally responsible for the clinic'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.

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

The term "medical director" means a physician, employed by or under contract with a clinic, who maintains an unencumbered physician license in accordance with chs. 458 (physicians), 459 (osteopathic physicians), 460 (chiropractors), or 461 (podiatrists), F.S. However, if the clinic is limited to providing services pursuant to chs. 457, 484, 486, 490, or 491, or part I, III, X, XIII, or

part XIV of ch. 468, F.S., the clinic may appoint a practitioner to serve as a "clinic director" who is responsible for the clinic activities.

Each clinic must file a notarized license application with AHCA by March 1, 2004, have a fixed location (mobile clinics must provide health care services only at a single location), and allow inspections by AHCA as a prerequisite for licensure. Applicants that submit an application before March 1 that meet all the requirements for initial licensure shall receive a temporary license until the completion of the initial inspection verifying that it meets all the requirements. However, a clinic offering magnetic resonance imaging (MRI) services may not obtain a temporary license unless it demonstrates to AHCA that it is making a good faith effort to obtain accreditation from a specified accreditation organization.

The agency may conduct unannounced inspections and the clinic must allow access to the premises and clinic records. An applicant must file a list of services that the clinic will provide, either directly by the applicant or through contractual arrangements with existing providers, along with the number and discipline of professional employees, and proof of financial ability to operate.

Background investigations and screenings are authorized for "applicants" who are defined as individuals who own or control, directly or indirectly, 5 percent or more of an interest in the clinic, medical or clinical directors, the financial officer, and clinic licensed medical providers. Such applicants must meet Level 2 screening criteria under ch. 435, F.S., and have had no prior violation of Level 2 crimes (including insurance fraud) within the past 5 years.[8] If an applicant has had a Level 2 violation,[9] (including insurance fraud) within the past 5 years, then a license may not be granted to the clinic. If applicants have had their civil rights removed due to Level 2 violations and 5 years have lapsed, then such applicant must show that his or her civil rights have been restored in order for a license to be issued. Requested information omitted from an application must be filed with AHCA within 21 days of receipt of the agency's request.

Licenses are renewed every 2 years and may not be sold, leased, assigned, or otherwise transferred. The agency is authorized to promulgate rules and establish fees that must be calculated to cover only the agency's costs in licensing and regulating clinics. Such fees are to be deposited in the Health Care Trust Fund. It is a third-degree felony to own, operate, or maintain an unlicensed clinic and persons found guilty of violating this provision a second or subsequent time commit a second-degree felony. Health care providers who are aware of the operation of an unlicensed clinic must report that facility to AHCA and failure to do so when the provider knows or has reasonable cause to suspect the clinic is unlicensed shall be reported to the provider's licensing board. It is also a third-degree felony for any person who knowingly files a false or misleading clinic license application or who files false or misleading information pertaining to the license.

Responsibilities for clinic operation are outlined to include the appointment of a medical or clinic director who must agree in writing to accept legal responsibility for specified activities including

[8] See footnote 1.
[9] This means if the applicant has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the Level 2 provisions including insurance fraud.

ensuring that practitioners maintain an active license which is appropriate for the level of care provided, ensure proper record keeping, and conduct reviews of clinic billings.[10] It further provides that all charges or claims made by a clinic that is required to be licensed, but that is not so licensed, are unlawful charges, and therefore not compensable, which is current law under s. 456.0375(4)(a), F.S. The agency may fine, suspend or revoke a clinic license that operates in violation of these provisions.

A clinic engaged in magnetic resonance imaging (MRI) services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, within 1 year after licensure, with an allowance for a single, six-month extension for "good cause." The agency may disallow an application for a clinic formed to avoid compliance with the accreditation requirements, whose principals were previously principals of an entity that was unable to meet the accreditation requirements. The bill also provides for AHCA to give a temporary credit (until September 2004) to a past waiver granted to an MRI clinic from a rule adopted by the Department of Health (DOH).[11] The rule (Rule 64-2002, F.A.C.) limits the number of health care clinics for which a medical or clinical director may maintain responsibility to no more that 5 clinics with no more than 200 licensees. The waiver allowed the medical or clinic director of one specific clinic to oversee ten clinics with no more than 200 licensees.[12]

The agency may institute injunctive proceedings in a court of competent jurisdiction to enforce the provisions of this act when the attempt by the agency to correct a violation through administrative fines has failed. Further, administrative actions challenging agency actions shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

The agency is authorized to impose administrative penalties against clinics of up to $5,000 per violation for violations of requirements of this part. In determining if a penalty is to be imposed, AHCA may consider factors like the gravity of the violation; actions taken by the owner, medical or clinic director to correct violations; any previous violations; and the financial benefit to the clinic of committing or continuing the violation. Each day of continuing violation constitutes an additional, separate, and distinct offense. Actions taken to correct violations must be documented in writing.

The bill provides that any unlicensed clinic that continues to operate after agency notification is subject to a $1,000 fine per day and any licensed clinic whose owner or director concurrently operates an unlicensed clinic is subject to a fine of $5,000 per day. The agency, as an alternative to administrative actions, must make a reasonable attempt to discuss each violation and recommended corrective action with the owner or director, prior to written notification. Further, instead of fixing a period for the clinics to enter into compliance with standards, the agency may request a plan of corrective action from the clinic which demonstrates a good-faith effort to remedy each violation. All fines are paid by any clinic into the Health Care Trust Fund.

---

[10] Many of the enumerated responsibilities are provided in current law under s. 456.0375(3) and (4), F.S.
[11] Presently, clinics are registered by DOH under s. 456.0375, F.S. This provision is repealed under this bill effective March 1, 2004.
[12] The waiver pertained to the Open Magnetic Imagining Company. Before Sept. 2004, the clinic must request a variance from AHCA under the Administrative Procedures Act (ch. 120, F.S.).

Section 5. Amends s. 456.0375, F.S., relating to clinic registration, to clarify that the term "clinic" does not include entities that own, are owned, or are under common ownership, directly or indirectly, with entities licensed or registered under chs. 390 (abortion), 394 (mental health), 395 (hospitals), 400 (nursing homes), 463 (optometry), 465 (pharmacy), 466 (dental), 478 (electrolysis), 480 (massage), 484 (optical), or 651 (continuing care), F.S.; community colleges or university clinics or clinical facilities affiliated with accredited medical schools.

Section 6. Amends s. 456.072, F.S., providing as grounds for health care professional disciplinary actions, to expand such actions to include, with respect to making a PIP claim, providers who intentionally submit a claim using a billing code that is greater than the amount that would be paid ("upcoding") and intentionally submitting a claim for payment of services that were not rendered. However, the term upcoding does not include otherwise lawful bills by independent diagnostic testing facilities.

Section 7. Amends s. 626.7451, F.S., to increase the fee that managing general agents (MGA) may charge by $15 (from $25 to $40). It provides that an MGA that collects a per-policy fee on behalf of an insurer must remit a minimum of $5 per policy to the insurer for the funding of a Special Investigations Unit dedicated to the prevention of motor vehicle insurance fraud, $2 per policy to fund the Division of Insurance Fraud within the Department of Financial Services, dedicated to the prevention and detection of motor vehicle insurance fraud, and $3 per policy to the Office of Statewide Prosecution, dedicated to the prosecution of motor vehicle insurance fraud.

Any insurer that writes directly without an MGA and that charges a per-policy fee may charge an additional $5 per policy to fund its Special Investigations Unit dedicated to the prevention of motor vehicle insurance fraud, $2 per policy to fund the Division of Insurance Fraud within the Department of Financial Services, dedicated to the prevention and detection of motor vehicle insurance fraud, and $3 per policy to the Office of Statewide Prosecution, dedicated to the prosecution of motor vehicle insurance fraud.

Section 8. Amends s. 627.732, F.S., to provide for changes to the provisions relating to "brokers" and to provide for definitions under the PIP insurance system. It amends the "broker" definition under the no-fault law which currently provides that PIP benefits are not payable to a broker of MRI services, to revise one of the exceptions for temporary leasing of medical equipment due to repair or maintenance. The bill extends the allowable 30-day lease period by an additional 60 days, when the owner certifies that the 60-day extension complies with current law. Current law allows the lease of such equipment not to exceed 30 days in a 12-month period. Such an extension will also apply to medical equipment or newly purchased or replacement equipment.

Definitions are added to include the following:

- "certify" means to swear or attest to being true or represented in writing.
- "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the language "signature on file" or any similar statement.
- "immediate personal supervision," as it relates to the performance of medical services by non-physicians not in a hospital, means that an individual licensed to perform the medical

service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can physically see the activities of all employees and respond immediately to any emergencies, if needed.

- "incident," with respect to services considered as incident to physician's licensed under ch. 458 (physician), 459 (osteopathic), 460 (chiropractic), or 461 (podiatric), F.S., if not furnished in a hospital, means such services must be an integral, even if incidental, part of a covered physician's service.
- "knowingly" means that a person, with respect to information, has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the information; and proof of specific intent to defraud is not required.
- "lawful" or "lawfully" means in compliance with all applicable criminal, civil, and administrative requirements of Florida and federal law related to the provision of medical services or treatment.
- "hospital" is a facility licensed under ch. 395, F.S.
- "properly completed" means providing truthful, complete and accurate responses to each applicable request for information or statement.
- "render" means to have properly licensed personnel actually physically perform the medical service or physically transfer the supplies to the insured incident to the provider's professional services. The term does not include scheduling medical services or ordering medical supplies for the insured.
- "upcoding" means an action that submits a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. Provides an exception for independent diagnostic testing facilities.
- "unbundling" means an action that submits a billing code that is properly billed under one billing code, but which has been separated into two or more billing codes, that would result in payment greater in amount than would be paid using one billing code.
- "independent diagnostic testing facility" means a fixed facility that performs the technical components of MRI and other tests and provides the professional components of such services with specified conditions.

Section 9. Amends s. 627.736, F.S., by revising provisions governing the submission and payment of personal injury protection benefits, charges for treatment, mental and physical examinations of injured persons, alternative dispute resolution and peer review procedures, attorney's fees, preferred provider policies, civil actions for insurance fraud, provisions relating to the Financial Services Commission, and other issues.

The bill provides that PIP benefits are not due or payable to an insured who commits insurance fraud if the fraud is admitted to in a sworn statement by the insured or if it is established in court. Such fraud shall void all coverage arising from the claim, regardless of whether a portion of the claim may be legitimate. Any benefits paid prior to the discovery of the fraud are recoverable by the insurer from the person who committed the fraud in their entirety and the insurer is entitled to costs and attorney's fees in any action in which it prevails.

It requires providers, when furnishing written notice to insurers of a covered loss and the amount thereof, to meet specific requirements which include properly completed billing statements, and for billings rendered by hospitals, compliance with applicable procedure codes. It specifically mandates that statements and bills from providers for medical services (other than hospitals) be submitted on properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the AMA Current Procedural Terminology (CPT) Editorial Panel and the Healthcare Correct Procedural Coding System (HCPCS). In determining compliance with applicable codes, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the HCPCS coding system in effect, the Office of the Inspector General, Physicians Compliance Guidelines and other authoritative treatises designated, by rule by AHCA.

It further requires that all providers, other that hospitals, include on the applicable claim form the professional license number of the provider on the line or space provided for "Signature of Physician or Supplier Including Degrees or Credentials." Currently, the universal claim form utilized by medical providers (except hospitals) is the HCFA 1500 form, but it does not require a license number. However, Medicare does require a provider to include his/her license number on the form under the "Signature of Physician…" line, which is entry #31. All statements and bills must be properly completed according to the requirements noted above, or the insurer shall not be considered to have been furnished with proper notice of such statement or bill.

Further, physicians, clinics, or other medical institutions, other than hospitals or emergency service providers, must furnish to the insurer an original completed disclosure and acknowledgment form which is countersigned by the insured, or guardian, upon receiving PIP medical benefits (services). The form, which is adopted by rule by the Financial Services Commission, requires the following:

- the insured, or guardian, has the right and duty to confirm that services were actually rendered.
- the insured, or guardian, was not solicited by any person to seek medical services.
- the provider has an affirmative duty to explain the services rendered so that the insured, or guardian, in countersigning the form, has informed consent.
- the licensed medical provider must sign, by his or her own hand, the disclosure and acknowledgment form, and
- such form may not be electronically furnished to the insurer.

Insurers or insureds are not required to pay claims or charges for treatments by providers, which were unlawful, were knowingly submitted as false or misleading statements, or were submitted on bills or statements that did not meet the requirements of being properly coded or submitted on requisite forms.

The bill provides that an insurer may change codes it determines to have been improperly or incorrectly coded, without affecting the right of the provider to dispute the change by the insurer. The insurer must contact the health care provider and discuss the reasons for the insurer's change, or make a reasonable good-faith effort to do so, before the insurer may change the provider's medical codes.

The bill clarifies the date, June 19, 2001, for PIP benefits for MRI services to take effect under the participating physician fee schedule of the Medicare Part B fee schedule under ch. 2001-271, Laws of Florida. This provision clarifies the specific date such services were to be compensated which was the date the Governor approved the bill and it became law. The bill further provides that such charges are not payable by the insurer or insured if no reimbursement is established under such schedules and clarifies that for medical treatments are rendered out of state the reimbursement amount is set for the area where the insured resides.

It authorizes the Department of Health (DOH), in consultation with the appropriate professional licensing boards, to establish by rule a list of diagnostic tests that are specifically deemed to be not medically necessary, and therefore not compensable, by January 1, 2004. The bill limits medical fees, products, or services for all treatments under PIP, beginning on October 1, 2003, to 200 percent of the allowable amount under the Medicare Part B participating physicians fee schedule in effect on July 1, 2003, for the area in which the services are rendered.
It requires the Financial Services Commission, beginning in 2004, to annually review any changes made to the Medicare Part B fee schedule and to determine the extent to which such changes apply in order to ensure availability and affordability of services. It provides that procedures or services currently under the workers' compensation fee schedule remain under that schedule. The bill does provide that if charges are not under either fee schedule (Medicare or workers' compensation), then a person may request that the Department of Financial Services, in consultation with AHCA, determine whether a charge is reasonable for reimbursement. Further, the bill provides that amounts charged for MRI services provided in facilities accredited by three specified accreditation organizations may not exceed 200 percent of the Medicare Part B participating physician fee schedule.

The bill removes the PIP arbitration provision which was declared invalid by the Florida Supreme Court in *Nationwide Mutual v. Pinnacle Medical, Inc.*, 753 So.2d 55 (Fla. 2000).

The bill provides for an anti-fraud financial incentive to consumers that if, based on a written report by a person, the insurer finds improper billing by a medical provider, the insurer would pay the person 20 percent of the amount of the reduction up to $500, or pay 40 percent, if the provider is arrested due to improper billing. Furthermore, it requires that an insurer may not systematically down code with the intent to deny reimbursement otherwise due and that such violation constitutes a material misrepresentation under the unfair or deceptive practices provisions of the Insurance Code.

It prohibits an insurers or its employees from improperly requiring a physician to materially change an opinion in an independent medical examination (IME) report, however, this does not preclude the insurer from notifying the physician of errors of fact in the report based upon information in the claim file; and provides that the denial of a payment as a result of such a changed option constitutes a material misrepresentation under the unfair and deceptive practices provisions. It provides that physicians preparing IME reports must maintain, for at least 3 years, copies of all examination reports as medical records and maintain, for at least 3 years, records of all payments for such examination reports.

The provision clarifies that this section does not prohibit an insurer that chooses not to offer a preferred provider policy from providing certain benefits pursuant to a contract entered into

directly or indirectly, with a licensed provider or hospital that establishes agreed upon amounts to be charged for services rendered to persons entitled to such benefits.

The bill limits the application of attorney's fees provisions for disputes between insureds and insurers (under s. 627.428, F.S.) by providing that the demand letter, alternative dispute resolution and peer review procedures apply. The bill expands the current presuit demand letter provision by stating that it is a condition precedent to filing "any action" under s. 627.736, F.S. (Under current law, demand letters are limited to actions for overdue claims.) The bill increases the time for insurers to respond to the demand letter from 7 business days to 15 calendar days. It states that, if the demand letter involves an insurer's withdrawal of payment for future treatment not yet rendered, no action may be brought against the insurer if, within 15 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment and provides a penalty the insurer must pay.

The bill provides that all parties in a PIP dispute may utilize a "medical peer review" (MPR) procedure to settle their differences without resorting to litigation. It provides that the MPR is administered by ACHA and will take effect October 1, 2003. The agency will contract with nationally accredited peer review organizations to address PIP issues of medical necessity, correct coding, the reasonableness of the amount charged, and whether the service or treatment is related to the injury covered by the policy.

The bill provides for definitions, a notice procedure which implements the MPR process, and qualifications of the "peer reviewer." A peer reviewer is defined as a health care practitioner or other person who is employed or under contract with a peer review organization, and who from other work derives less than 25 percent of his or her income from insurers of any kind. As to issues of medical necessity, the bill provides that the health care organization must use a practitioner who is licensed under the same chapter as the practitioner involved in the dispute and have an active patient practice of a least 8 hours per week.

It provides ACHA with rule making authority, requires the agency to take reasonable measures to ensure that the peer review organization and peer reviewers are not biased and that the MPR is based on the documents and explanations submitted by the parties to the review. The peer review procedures are: notice by a claimant or insurer initiates the peer review process and each party must submit documents and explanatory statements to the reviewer within 10 days of receipt of the notice for peer review; the peer reviewer may schedule a telephone conference with the parties (e.g., claimant or provider and insurer); and the reviewer's recommendation must be issued within 10 days of receipt of the parties' documentation and statements. Dispute costs are split by the insurer and claimant, but are paid up to $500 by the insurer if the reviewer recommendation is greater than the amount offered by the insurer, with the remainder divided equally among the parties. The MPR is intended to be a "paper review" of the issues presented to the reviewer.

The insurer has no obligation to pay claimant's attorneys fees if the insurer pays the amount recommended by the peer reviewer, a 10 percent penalty, and statutory interest within 10 days of the reviewer's recommendation. If the insurer declines to participate in the MPR or declines to pay the amounts recommended, the insurer remains potentially liable for reasonable attorney's fees. However, if the claimant declines to participate or declines to accept payment from the

insurer; the insurer is not liable for attorney's fees. Further, the decision of the peer reviewer is not binding on any party and the parties retain access to courts.

The MPR is a condition precedent to the filing of a court action and a party is precluded from filing a court action related to the dispute amount while the dispute is pending. Either party may decline to participate in the MPR process as to the entirety or any item in dispute and should the insurer decline to participate or decline to pay the amount recommended, the insurer remains liable for reasonable attorney's fees under the Insurance Code and damages under s. 624.155, F.S. Should the claimant decline to participate or declines to accept payment from the insurer, the insurer is not liable for attorney's fees. The decision of the reviewer is not binding and the parties retain access to court. A party may seek judicial review of the peer reviewer recommendation to determine whether the recommendation was reasonable. Should the court declare the recommendation to be unreasonable, the peer review organization shall provide a different peer reviewer to review the issues in the dispute and issue a recommendation, and the peer review process shall proceed as if no action has been filed. It further provides that documents related to the MPR may be introduced in court if such documents are admissible under the Florida Evidence Code.

The bill also provides for a alternative dispute resolution (ADR) process similar to the current mediation law for issues that do not apply to the medical peer review (MPR) procedure. For the purpose of this section, the term "mediation" means alternative dispute resolution and the term "mediator" means the person attempting to resolve the dispute. The bill provides for mediator (e.g., reviewer) qualifications that includes specialized training and approval by the department or office. The choice to use ADR is optional, and either party may decline to participate. However, utilization of ADR, like MPR, affects the payment of costs and the application of attorney's fees, otherwise required under the provisions of the Insurance Code or for damages under s. 624.155, F.S., in the following manner:

(a) If mediation (e.g., ADR) is requested by the insurer, the insurer pays all mediation costs. Otherwise, the costs are paid equally by both parties (except as provided in (e), below).

(b) Consumer affairs specialists, within the Department of Financial Services, are available to consult with persons not represented by an attorney.

(c) If mediation is unsuccessful (the parties fail to reach an agreement), the neutral mediator selected by the Department of Financial Services or the Office of Insurance Regulation, issues a written report recommending the amount, if any, payable by the insurer.

(d) An insurer is liable for attorney's fees, if it declines to participate in mediation or declines to pay the mediator's recommended amount. In such cases, a contingency risk multiplier (ranging from 1.0 to 2.5, pursuant to case law) will apply to attorney's fees only if the court determines and states explicitly the particular legal or factual issue involved and provides appropriate reasons. However, a risk multiplier of 2.5 (highest level) would be applied if the court determines that the issue is of great public importance that the public interest requires determination of that issue. (Note: See (f) below which requires insurers to pay a limited attorney's fee under certain circumstances.)

(e) An insurer is not liable for attorney's fees (except as provided in (f), below), if the claimant declines to mediate, declines to settle the matter in accordance with the mediator's recommendation, or if the insurer pays the amount demanded or mediator's recommended amount, plus mediator's fees and interest.

(f) An insurer is liable for reasonable attorney's fees of up to a $1,000, as determined by the mediator, if the mediator recommends an amount that is in excess of the amount that the insurer has paid.

The bill further provides that a party to the mediation is not required to attend the mediation, provided that any representative of the party participating in the mediation must have the authority to make binding decisions. As with MPR, a party make seek judicial review of the mediator's recommendation to determine whether the recommendation was reasonable.

The bill provides that if the Financial Services Commission determines that cost savings under PIP have been realized due to the provisions in this act, prior reforms, or other factors, the Commission, by rule, may increase the minimum $10,000 benefit coverage requirement. However, in establishing the amount of the increase, the Commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the PIP coverage with limits of $10,000.

Section 10. Amends s. 627.739, F.S., relating to PIP deductibles, to change the calculation of the PIP deductible to require that it must be applied to 100 percent of medical expenses, rather than to the current 80 percent of expenses that PIP pays. This provision has the effect of requiring PIP to pay more in benefits than it does now if a deductible is elected. For example, under current law: $5,000 medical bill, PIP pays 80 percent, or $4,000, minus $2,000 deductible = $2,000. Under this provision: $5,000 medical bill, minus $2,000 deductible, is $3,000. PIP pays 80 percent X $3,000= $2,400.

This provision also changes the calculation of the PIP deductible so that the full $10,000 in PIP benefits can be obtained. This has the effect of requiring PIP to pay more than it does currently if a deductible is elected. Presently, a $2,000 PIP deductible operates to lower the maximum PIP benefits to $8,000 because the law provides that the deductible is deducted from the "benefits otherwise due." Under these provisions, the PIP deductible will be applied in a way similar to how a deductible is applied in a health insurance policy, to be the out-of-pocket expense that must be incurred before the policy benefits are paid.

Under current law, an insured may select a deductible to apply to the named insured and dependent relatives residing in the same household, but may not elect a deductible to apply to any other person covered under the policy. Deductibles range in amounts of $250, $500, $1,000 and $2,000 and are deducted from PIP medical benefits, otherwise due, but not from death benefits. Insureds selecting a deductible have an appropriate reduction of premium associated with the deductible selected.

Section 11. Amends s. 768.79, F.S., relating to offer of judgment and demand for judgment, to apply this provision to all PIP claims. Currently, the offer of judgment provision applies to all other civil actions for damages. The Third District Court of Appeal held in *U.S. Security*

Insurance Co. v. Cahuasqui, 760 So.2d 1101 (Fla.App. 3 Dist. 2000), that the offer of judgment section does apply to PIP cases (Circuit courts in other districts have differed). The Third District holding has precedential value statewide unless and until another District Court or the Florida Supreme Court holds otherwise. The offer of judgment provision is a tool that both parties can use, which helps encourage reasonable settlement offers and demands for judgment.

Section 12. Amends s. 817.234, F.S., relating to false and fraudulent insurance claims, to provide that it shall constitute a material omission and insurance fraud for any physician or other provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the patient or intends to waive a deductible or co-payment, or does not for any other reason intend to collect the total amount of such charge.

It provides that is a third-degree felony for insurers to change an opinion in a independent medical examination (IME) report or direct the physician preparing the report to change his or her opinion, provided that this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon the information in the claim file.

It prohibits solicitation, with intent to defraud, of a PIP accident victim during the 60-day period crash reports are confidential, and increases the penalty from a third to a second-degree felony. Provides for a 2-year minimum mandatory sentence. It prohibits solicitation of a PIP accident victim, by any means of communication (other than advertising), during 60-day period the crash (accident) report is confidential and provides that it is a third-degree felony. It prohibits the solicitation of PIP accident victims after 60 days (after report becomes public) by specified professionals, e.g., lawyers, health care providers defined under s. 456.001, F.S., (which includes all individual health care professions and occupations licensed in Florida), clinic owners or medical directors, at the victim's residence or by phone. It provides that this is a third-degree felony.

It provides that charges for services rendered by a person who violates solicitation provisions are not compensable by the insurer or insured. It provides that it is a second-degree felony to organize, plan, or participate in an intentional motor vehicle collision and requires a 2-year minimum mandatory sentence.

Section 13. Amends s. 817.236, F.S., to provide for increasing the penalty, from a first-degree misdemeanor to a third-degree felony, for presenting a false or fraudulent motor vehicle application.

Section 14. Creates s. 817.2361, F.S., to provide that it is a third-degree felony to present a false or fraudulent motor vehicle insurance card.

Section 15. Amends s. 922.0022, F.S., the Offense Severity Ranking Chart law, to increase the ranking of the following crimes: soliciting an accident victim with intent to defraud; unlawfully obtaining or using a confidential crash report; filing a false motor vehicle insurance application; operating an unlicensed clinic or filing false clinic license information; and organizing, planning, or participating in an intentional motor vehicle collision.

Section 16. Provides effective date language related to section 5 and part of section 9 of the bill.

Section 17. Repeals s. 456.0375, F.S., effective March 1, 2004. This section currently provides for the registration and regulation of health care clinics under the Department of Health (DOH). It is being repealed because under Section 4 of this bill, clinic regulation and licensure is placed within the Agency for Health Care Administration (AHCA). Until March 1, 2004, DOH will continue to register clinics, but that responsibility will be taken over by AHCA at that time.

Section 18. Provides effective date language related to portions of sections 9, 10, and 12 of the bill..

Section 19. Provides that by Dec. 31, 2004, the Department of Financial Services, the Department of Health, and the Agency for Health Care Administration must each submit a report on the implementation of this bill and recommendations, if any, to further improve the automobile insurance market, reduce costs and fraud and abuse, to the President of the Senate and the Speaker of the House of Representatives.

Section 20. Provides an appropriation of $2.5 million from the Health Care Trust Fund, and 51 FTE's authorized to AHCA to implement the provisions of this bill.

Section 21. Provides an effective date of July 1, 2003, except as otherwise expressly provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill does not reduce PIP benefits, but puts limitations on receiving PIP benefits, such as medical fee schedules, and limits on recovery of attorney fees. Such limitations may raise the constitutional issue of whether the No-Fault Law continues to provide a reasonable alternative remedy for redress of injury, in exchange for limiting the right to sue in tort for pain and suffering and other non-economic damages, based on the constitutional right of access to courts for redress of injury under s. 21 of Article I of the Florida Constitution. The Legislature can abolish a judicial remedy provided a reasonable alternative remedy, commensurate benefit or overpowering public necessity for the

abolishment is shown and there is no alternative method for meeting that public necessity. See *Kluger v. White*, 281 So.2d 1 (Fla. 1973); *Psychiatric Assoc. v. Siegel*, 610 So.2d 419 (1992).

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

The bill requires a $2,000 biennial licensure fee for health care clinics under Section 4 of this bill. (Please see discussion under Private and Government Sector Impact, below.)

The bill increases the per-policy fee that many managing general agents (MGA) currently charge, from $25 to $40 per policy. Specifically, it requires MGAs, who collect per-policy fees, to remit $5 to fund insurers' Special Investigation Units, $2 to fund the Fraud Division within the Department of Financial Services, and $3 to fund the Office of Statewide Prosecution for prevention, investigation, and prosecution of motor vehicle insurance fraud. An MGA would keep the other $5 (since the total increase under the bill is $15.00.) Insurance companies that write directly, without a managing general agent, and that charge a per-policy fee, may charge additional policy fees up to the amounts specified above to fund each of those entities.

Committee staff has been unable to obtain from the Department of Financial Services any estimate of the revenue that will be generated from this provision. (See discussion below under Private and Government Sector Impact.) Both the Department of Financial Services and the Department of Legal Affairs will require appropriations, or will have to process budget amendments, to spend any new funds generated under this provision.

B. Private Sector Impact:

Any reduction in insurance fraud, litigation expenses, and medical costs resulting from this legislation should reduce insurer loss experience and result in premium savings for PIP policyholders. This may also result in increasing the $10,000 PIP limits due to the provision that the Financial Services Commission may determine whether cost savings under these PIP reforms have been realized, and if cost savings have been achieved, the Commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of the increase, the Commission must initially determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized by the $10,000 PIP coverage.

Applicants for health care clinics licenses will incur costs associated with licensing, inspections, background screenings, and other regulations imposed by this amendment. However, stricter regulation of such clinics by AHCA will benefit insureds and insurers and could reduce overall fraud costs.

Clinics offering magnetic resonance imaging (MRI) services must be accredited by one of three national accreditation organizations under the provisions of this bill and will have to pay thousands of dollars before they can achieve accreditation. According to representatives with AHCA, one accreditation organization charges a minimum of

approximately $8,500 per facility location, takes from six to eight months to accredit the facility, and requires re-accreditation every three years.

Medical providers will be subject to fee schedules that may reduce current charges for services and treatment covered by PIP, but which may result in prompt payment from insurers. Such fee schedules could also lower litigation costs by reducing the number of disputes currently occurring between providers (or insureds) and insurers over the proper amount of reimbursements.

Litigation costs could be reduced by having parties to PIP disputes settle these issues through medical peer review (MPR) or alternative dispute resolution (ADR) processes rather than by filing lawsuits in court, thus reducing the likelihood and amount of attorney's fees required to be paid by insurers. Limiting attorney's fees will help to reduce the incentive of providers to litigate PIP disputes, thereby lowering PIP costs and premiums. Under this bill, insurers who request ADR will have to pay the reviewer's costs, otherwise such costs are paid equally by both parties. In certain instances, insurers will also have to pay attorney's fees up to $1,000, if the ADR reviewer's recommended amount is more than the amount the insurer has paid. Under the MPR, insurer's will pay reviewer costs up to $500, if the reviewer's recommended amount is greater than the amount offered in writing to the claimant by the insurer.

There will be a need for more reviewers for MPR and ADR pertaining to PIP disputes under this bill, but the number cannot be estimated.

The bill will benefit insurer Special Investigative Units by providing those Units with greater resources ($5 per policy from MGA's fees; and up to $5 from insurers (who do not use MGA's and who exercise the option to charge per-policy fees) to prevent and investigate motor vehicle insurance fraud. Committee staff has been unable to determine the amount of revenues that will be generated by the collection of per-policy fees. According to representatives with the Department of Financial Services, with the exception of one company, the larger insurers do not use managing general agents and do not charge per-policy fees. However, smaller insurers, particularly non-standard (high risk) insurers, typically utilize MGAs who charge per-policy fees and thus will be required to fund the Units under the provisions of this bill.

C. Government Sector Impact:

This bill requires the Agency for Health Care Administration (AHCA) to license, inspect, and enforce the overall regulation of certain health care clinics. Clinic registration is currently carried out by the Department of Health (DOH). The bill transfers this responsibility to AHCA and creates greater regulatory responsibilities than are currently vested in DOH. The Agency for Health Care Administration will establish clinic licensure fees by rule and such fees must reasonably cover the costs of all regulatory activities, not to exceed $2,000. The bill provides that the agency shall adjust its fees annually by the change in the Consumer Price Index. Clinics are required to renew their registration biennially.

Fiscal Analysis from the Agency for Health Care Administration

The fiscal analysis from AHCA is based on the new licensure program for "Health Care Clinics." This program will be the second largest licensure program in the agency. AHCA estimates that provisions of this bill will increase the licensure and inspection from 2,547 health care clinics to 3,000 over a 2 year period (1,500 clinics would be licensed in the first year and 1,500 the following year).

AHCA projects that revenues will be collected at the maximum allowable rate of $2000 for each licensee and that the inflation factor permitted by section 4 of the bill will cover future funding needs. AHCA's estimates phase in 26 field office staff (24 Registered Nurse Specialists, 1 Registered Nurse Consultant, and 1 Health Facility Evaluator Supervisor) to perform surveys, inspections and complaint investigations; 7 staff in the General Counsel's Office; 1 information systems professional; 2 background screening staff; and 15 licensure staff.

Total Revenues and Expenditures	FTEs	FY 2003-04	FY 2004-05
Total Revenues:		$3,000,000	$3,000,000 + CPI
Total Expenditures:	51.0	$2,470,026	$3,577,461
Difference: (Total Revenues minus Total Expenditures)		$ 529,974	n/a

As noted above, the bill may benefit the Division of Insurance Fraud within the Department of Financial Services, and the Office of Statewide Prosecution by providing those entities with greater resources through the collection of specified per-policy fees to investigate and prosecute motor vehicle insurance fraud. However, committee staff has not been able to determine the amount of revenues that will be generated by the collection of per-policy fees. According to representatives with the Office of Insurance Regulation, with the exception of one company, the larger insurers do not use managing general agents and do not charge per-policy fees. However, smaller insurers, particularly non-standard (high risk) insurers, typically utilize MGAs who charge per-policy fees and thus will be required to fund the entities under the provisions of this bill.

The creation of new PIP insurance fraud crimes and added penalties provided for in the bill may increase jail and prison costs associated with incarcerating those individuals caught committing those crimes.

Additional work-load is expected for the Department of Financial Services to administer the alternative dispute resolution program, adopt appropriate rules, provide consumer affairs specialists to consult parties not represented by an attorney, and approve reviewer qualifications established under this bill.

The Department of Health indicates the boards will have some costs to hold public meetings and to submit recommendations to the Department for rules on medically unnecessary tests for PIP cases.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.