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/SB 32-A

SPONSOR: Banking and Insurance Committee and Senator Alexander

SUBJECT: Motor Vehicle Insurance

DATE: May 15, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.				
3.				
4.				
5.				
6.				

I. Summary:

Committee Substitute for Senate Bill 32-A 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 to the PIP (personal injury protection) automobile insurance laws. The bill does the following:

Criminal Penalties for PIP Fraud

The bill 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 minimum mandatory penalties for intentionally causing motor vehicle accidents and soliciting accident victims during the 60-day period accident reports are confidential; and increases the ranking of solicitation crimes and certain motor vehicle insurance fraud offenses under the Offense Ranking Chart law.

[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 two provisions which are similar, but more specific: minimum mandatory penalties for intentionally causing motor vehicle accidents and soliciting accident victims during the 60-day period accident reports are confidential; and allowing insurers to recover benefits paid prior to the discovery of insurance fraud from the person who actually committed the fraud. (The prevailing party may also obtain costs and attorney's fees in any action in which it prevails.)

Regulation of Health Care Clinics

The bill 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; 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.,[2] 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; 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; and requires magnetic resonance imaging (MRI) clinics to become accredited by specified national organizations within 1 year of licensure.

It authorizes AHCA to promulgate rules, 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.

PIP Payment and Billing Provisions, Unnecessary Diagnostic Tests, Independent Medical Examinations

This legislation revises provisions governing the submission and payment of personal injury protection benefits so that statements are in compliance with specified coding and billing requirements. Authorizes consideration of certain evidence which may be used to determine whether charges for a service are reasonable. Specifies that insureds and insurers are not required to pay for charges that are not lawful, contain false or misleading statements, or are improperly upcoded or downcoded. Clarifies that allowable amounts for specified tests under current law are under the participating physician fee schedule and adjusted annually.

The bill 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 during the initial treatment of the insured, and that such form must be signed by the insured, or guardian, and provider, attesting to the fact that services were rendered. Requires providers, except for hospitals, to maintain a patient log signed by the patient by date of service that is consistent with services being rendered. Hospitals must, however, maintain specified medical records and make such records available to insurers upon request. Provides that insurers may not systematically downcode with the intent to deny reimbursement otherwise due.

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

[2] 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.

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.

The bill authorizes the Department of Health, in consultation with the appropriate medical boards, to establish by rule a list of diagnostic tests that are not medically necessary, and therefore not compensable, by January 1, 2004. Requires that only Florida physicians may conduct independent medical examinations; prohibits insurers or their employees from improperly requiring physicians to materially change independent medical examination (IME) reports (provided that this does not preclude the insurer from notifying the physician of errors of fact in the report based on information in the claim file); and, mandates physicians who prepare IME reports, and physicians rendering expert opinions on behalf of persons claiming PIP benefits, 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.

Increased PIP Benefits by Financial Services Commission

It 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

This legislation 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.

Deductibles

The bill changes 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. It also changes the calculation of the PIP deductible so that the full $10,000 in PIP benefits can be obtained. This latter provision has the effect of requiring PIP to pay more than it does currently if a deductible is elected. The bill eliminates the $2,000 PIP deductible, thus the deductibles would be: $250, $500, and $1,000. The bill further provides that liability suits may be brought by the injured person to recover the amount of his or her PIP deductible from the at-fault driver.

PIP Reports to the Legislature

The bill requires the departments of Financial Services and Health, and the Agency for Health Care Administration to each submit a report by December 31, 2004, on the implementation of this bill and recommendations, if any, to further improve the automobile insurance market, and reduce costs, fraud, and abuse, to the President of the Senate and the Speaker of the House of

Representatives. The report by the Department of Financial Services must include a study of the medical and legal costs associated with PIP claims.

Sunset Provision

The bill provides that effective October 1, 2007, specified sections of the Motor Vehicle No-Fault Law are repealed, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after October 1, 2006. Authorizes insurers to provide, in all policies issued or renewed after October 1, 2006, that such policies may terminate on or after October 1, 2007.

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, 627.732, 627.736, 627.739, 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 section 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.[3] 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[4] 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.

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

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.

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 liability (BI) 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 is not financially responsible at the time of an 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[5] did not go far enough in attacking the problems of fraud and abuse occurring within the PIP system. There was

[5] 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.

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:

- 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 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.

• 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.

- 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.

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.

Organizations that accredit MRI facilities may charge fees in the thousands of dollars and may take several 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.

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.

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, increases criminal penalties, provides for billing and coding requirements; revises the calculation of deductibles; 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 problems 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, 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. The bill 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 from agencies that either prepare or receive such reports, during the 60-day period such reports are confidential, must 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.

The bill 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 under contract with one or more insurers and such contract must state that the information contained in crash reports will not be used for commercial solicitation of accident victims or knowingly disclosed to third parties. A copy of the contract must be furnished by the vendor to the agency issuing the crash report. The bill provides that it is a third degree felony for vendors to knowingly use confidential information in violation of their contractual agreement.

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, however, may issue initial licenses for less than the full 2-year period by charging a prorated licensure fee and specifying a different renewal date than would otherwise be required. The agency is further 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 16, 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 chs. 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, 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 presents evidence satisfactory to AHCA that it is making a good-faith effort and substantial progress in obtaining accreditation from a specified accreditation organization. Mobile clinics must provide to AHCA, at least quarterly, their projected street locations to enable the agency to locate and inspect the clinic.

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 for the first year. As an alternative to submitting financial information, the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic.

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.[6] If an applicant has had a Level 2 violation,[7] (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. The agency may deny or revoke a license if the applicant falsely represents any material fact or omits such a material fact from its application.

Licenses are renewed every 2 years and may not be sold, leased, assigned, or otherwise transferred and are valid only for the clinic owners and location for which originally issued. When transferring the ownership of a clinic, an application for a change of ownership is required only when 45 percent of more of ownership voting shares, or controlling interest, is transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a 2-year period that cumulatively total 45 percent or greater.

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. Criminal penalties are authorized to provide that it is a third-degree felony to establish, own, operate, manage, or maintain an unlicensed clinic and persons found guilty of violating this provision a second or subsequent time commit a second-degree felony. 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. 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. Clinics are subject to specific fines for enumerated violations which include daily fines for noncompliance for clinics that fail to cease operations after agency notification.

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 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.[8] 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.

[6] See footnote 1.
[7] 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.
[8] Many of the enumerated responsibilities are provided in current law under s. 456.0375(3) and (4), F.S.

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, 6-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).[9] The rule (Rule 64-2002, F.A.C.) limits the number of health care clinics for which a medical or clinic director may maintain responsibility to no more that five 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.[10]

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, if a clinic violates 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 the clinic into the Health Care Trust Fund.

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.

[9] Presently, clinics are registered by DOH under s. 456.0375, F.S. This provision is repealed under this bill effective March 1, 2004.

[10] 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 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.

Section 7. 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 who charges or receives compensation for any use of medical equipment and is *not* the 100 percent owner or lessee of such equipment. It revises one of the exceptions for temporary leasing of medical equipment due to the pending arrival and installation of newly purchased medical equipment or replacement for the 100 percent-owned medical equipment. The bill extends the current allowable 30-day lease period by an additional 60 days as applicable to MRI equipment if 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.

Definitions are added to include the following:

- "certify" means to swear or attest to being true or represented in writing.
- "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 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 substantial compliance with all relevant 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, substantially complete and substantially accurate responses as to all material elements to each applicable request for information or statement.
- "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 magnetic resonance imaging facilities which globally combine both the technical and professional components for services, if the amount of the global bill is not more than the components if billed separately.

- "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.

Section 8. 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, 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 prevailing party is entitled to costs and attorney's fees in any action in which it prevails.

The bill revises provisions relating to provider charges to specify that providers may charge the insurer and injured party only a reasonable amount pursuant to this section if the insured or guardian countersigns the properly completed claim form or bill. With respect to a determination of whether a charge for a service is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile insurance coverages. The bill also provides that insurers or insureds are not required to pay for charges for any service or treatment which was not lawful, contains a false or misleading statement, were submitted on bills or statements that did not meet the requirements of being properly coded, were upcoded, or unbundled, or were for medical services billed by a physician (not provided in a hospital), unless the services are rendered by such physician and incident to his/her services and included on the physician's bill.

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. Prior to changing a code, 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 that the allowable amounts for medically necessary nerve conduction tests, under specified conditions, will be under the "participating physician fee schedule" of the Medicare Part B fee schedule and adjusted annually on August 1 to reflect the prior calendar year's changes in the Medical Care Item of the Consumer Price Index (CPI) for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics. The CPI provisions also pertain to MRI services.

The bill 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 removes the PIP arbitration provision which was declared invalid by the Florida Supreme Court in *Nationwide Mutual v. Pinnacle Medical, Inc.*, 753 So2d 55 (Fla. 2000).

The bill provides that statements and bills for medical services rendered by any physician, hospital, clinic or other institution must be submitted on properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, or other applicable forms. All billings must follow the Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and HCPCS. Providers, other than hospitals, must 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. 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. All statements and bills must be properly completed as to all material provisions 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, hospitals, or other medical institutions, other than emergency service providers or for treatments rendered by an ambulance provider, 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). This provision applies only to the *initial treatment* of services for the insured by the provider. The form, which must be adopted by rule by the Financial Services Commission, requires the following:

- the insured, or guardian, to attest that the services were actually rendered and that they have 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 from the provider.
- the provider rendering services explained the services to the insured, or guardian. (and)
- if the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

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 provider must sign, by his or her own hand, the disclosure and acknowledgment form; and, the form may *not* be electronically furnished to the insurer which means the original executed form must be provided to the insurer. Countersigning by the insured or guardian is not required for reading diagnostic tests that are not required to be performed in the presence of the insured.

For subsequent services or treatments which are provided after the initial provision of services or treatments, the bill requires providers to maintain a patient log signed by the patient in

chronological order by date of service that is consistent with services being rendered to the patient as claimed. In lieu of maintaining a patient log, hospitals must maintain medical records as required by s. 395.3025, F.S., and make such records available to insurers upon request.

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.

The bill requires that only Florida physicians may conduct independent medical examinations (IMEs) and provides that physicians preparing IME reports at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming PIP benefits, 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. It prohibits insurers or its employees from improperly requiring a physician to materially change an opinion in an 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.

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. 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 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 9. 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.

The bill also provides that liability suits may be brought for the amount of the deductible that is not paid by PIP. The bill further eliminates the $2,000 deductible, thus allowing the range of deductibles to be $250, $500, and $1,000.

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 10. 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. However, this provision does not apply to physicians or other providers who waive deductibles or copayments or reduce their bills as part of a bodily injury settlement or verdict.

It provides that is a third-degree felony for insurers to change an opinion in an 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 makes it unlawful for any person intending to defraud any other person to solicit any business from a person involved in a motor vehicle accident for the purpose of adjusting or settling a motor vehicle tort claim for PIP benefits, 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 practitioners 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 11. 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 12. 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 13. 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 14. Provides that s. 456.0375(1)(b), F.S., (Section 5 of the bill) is intended to clarify legislative intent and that section, as amended, shall act retroactively to October 1, 2001, which was the effective date of the law which created s. 456.0375(1)(b), F.S. (Chapter 2001-163, L.O.F.).

Section 15. 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 16. Provides for various effective dates. The increase in benefits approved by the Financial Services Commission (Section 8 of the bill) shall apply to new and renewal policies that are effective 120 days after the Commission order becomes final. The provision relating to deductibles under subsection (2) of s. 627.739, F.S., shall apply to new and renewal policies issued on or after October 1, 2003. The demand letter provisions will apply to actions filed on or after the effective date of this bill (July 1, 2003); and the provisions which apply to IMEs shall apply to examinations conducted on or after October 1, 2003.

Section 17. Provides that by December 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. The report by the Department of Financial Services must include a study of the medical and legal costs associated with PIP claims.

Section 18. 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 19. Provides that effective October 1, 2007, specified sections of the Motor Vehicle No-Fault Law are repealed, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after

October 1, 2006. Authorizes insurers to provide, in all policies issued or renewed after October 1, 2006, that such policies may terminate on or after October 1, 2007.

Section 20. Provides that if any law that is amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature, such laws must be construed as if they had been enacted during the same session of the Legislature, and full effect, if possible, should be given to each.

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.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

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

B. Private Sector Impact:

Any reduction in insurance fraud or abuse, or 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.

Consumers who select deductibles will benefit under the provisions of this bill because it requires PIP to pay more in benefits than it does now if a deductible is elected. The calculation of the deductible is also changed so that the full $10,000 in PIP benefits can

be obtained. The bill also provides that liability suits may be brought for the amount of the deductible that is not paid by PIP.

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

Consumers receiving magnetic resonance imaging (MRI) services at clinics will benefit because these clinics will be held to higher standards due to the fact they must meet criteria for accreditation by one of three national accreditation organizations. Such clinics will have to pay thousands of dollars to achieve accreditation. For example, according to representatives with AHCA, one accreditation organization charges approximately $8,500 per facility location, takes several months to accredit a facility, and requires re-accreditation every 3 years.

Litigation costs could be reduced due to the provisions in the bill which broaden the application of the presuit demand letter to cover all PIP disputes and which gives insurers more time to respond to demand letters. Parties could settle many PIP disputes rather than file lawsuits, thus reducing the amount of court costs and attorney's fees.

C. Governmental 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 $2,000 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

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.

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.