HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 119 Motor Vehicle Insurance
SPONSOR(S): Insurance & Banking Subcommittee; Boyd and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1860

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	10 Y, 5 N, As CS	Reilly	Cooper
2) Civil Justice Subcommittee	10 Y, 5 N	Thomas	Bond
3) Health & Human Services Committee			
4) Economic Affairs Committee			

SUMMARY ANALYSIS

CS/HB 119 creates a new no-fault motor vehicle insurance system, the Emergency Care Coverage (ECC) Law, to replace the personal injury protection (PIP) system. While the ECC system represents a significantly different approach to no-fault law, it retains many aspects of PIP. ECC is identical to PIP with respect to persons covered by the no-fault policy, the amount of mandated coverage ($10,000), and the availability of lost wage and funeral benefits.

The distinguishing feature of an ECC policy is that coverage for medical services is dependent upon the severity of the injury. Specifically, medical benefits are payable only for:

- Emergency transport and treatment by licensed ambulance providers within 24 hours after the accident.
- Emergency services and care rendered at a hospital within 72 hours after the accident.
- Services and care rendered to an insured who is admitted to a hospital within 72 hours after the accident.
- Services and care rendered to an insured who is determined more than 72 hours after the accident to have an emergency medical condition related to the initial diagnosis and arising from the motor vehicle accident.
- If the insured receives services and care pursuant to 2), 3), or 4), subsequent services and care directly related to the medical diagnosis arising from the accident, subject to the following:
    - The diagnosis must be rendered in a licensed hospital and rendered by a physician licensed under chapter 458, F.S., or a licensed osteopathic physician and
    - The care and services must be rendered by a physician licensed under chapter 458, a licensed osteopathic physician, or a licensed dentist, licensed physician assistant, or a licensed registered nurse practitioner.

The ECC Law also:

- Caps attorney fee awards in individual and class action no-fault disputes, and bars the use of contingency risk multipliers in such cases.
- Creates rebuttable presumption that a diagnosis of emergency medical condition is correct.
- Tolls the 30-day payment period when fraud is suspected under specified conditions.
- Bars payment of any ECC benefits to persons who submit false statements or false information.
- Provides that compliance with ECC policy terms is a condition precedent to receipt of benefits.
- Creates rebuttable presumption that an insured's failure to appear for two examinations (mental or physical) is an unreasonable refusal or failure to submit to examination.
- Provides that compliance with all ECC policy terms is a condition precedent to receipt of policy benefits, including submission to examination under oath.

The bill provides for a single motor vehicle crash report form and requires insurers to use forms and rates that reflect the ECC Law for no-fault policies issued or renewed on and after October 1, 2012.

By addressing costs drivers in the current PIP system, the bill is expected to have a positive fiscal impact on motor vehicle insurance policyholders. The fiscal impact on state and local governments is unknown.

Except as otherwise provided, the bill is effective October 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Motor Vehicle Accident Reports

For motor vehicle accidents, s. 316.066, F.S., provides for the filing of a Long-Form or Short-Form Crash Report. The more detailed long-form report must be completed by a law enforcement officer only when the accident:

- Results in injury or death; or
- Involves a hit and run or intoxicated driver.

Completed long-form reports must be filed with the Florida Department of Highway Safety and Motor Vehicles (DHSMV). In other cases, a short-form report may be completed by a law enforcement officer or the parties involved in the accident. Short-form reports prepared by law enforcement officers are maintained by the local law enforcement agency and are not submitted to the DHSMV.

No-Fault Motor Vehicle Insurance

Florida's Motor Vehicle No-Fault Law (the "No-Fault Law)[1] requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. Florida is one of 12 states[2] with no-fault motor vehicle[3] insurance provisions. The purpose of the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida motorists are required to carry a minimum of $10,000 of PIP insurance and $10,000 of property damage liability coverage.[4,5]

Florida's PIP System

Legislative History

In 1971, Florida became the second state in the country to adopt a no-fault motor vehicle insurance plan, which took effect January 1, 1972. Since its enactment, various changes have been made to the No-Fault Law.

In 2000, a Statewide Grand Jury found rampant fraud in the PIP system. Reform legislation was enacted in 2001,[6] which adopted many of the Grand Jury's recommendations. These included requiring certain health care clinics to register with the Department of Health and providing criteria for medical directors; applying fee schedules for specified procedures; limiting access to motor vehicle crash

[1] Sections 627.730-627.7405, F.S.
[2] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance. The systems in New Jersey, Pennsylvania, and Kentucky are sometimes separately categorized as "choice" no-fault states, as motorists in these states have the option to reject the no-fault limitation on lawsuits and retain the right to sue for their injuries. See the Insurance Information Institute's update on "No-Fault Auto Insurance." *Available at*: http://www.iii.org/media/hottopics/insurance/nofault/ (last visited Jan. 23, 2012).
[3] "Motor vehicle" is defined in s. 627.732, F.S., and includes private passenger motor vehicles and commercial motor vehicles.
[4] Section 627.7275, F.S.
[5] Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for bodily injury and property damage liability at the time of motor vehicle accidents or when serious traffic violations occur.
[6] Chapter 2001-271, L.O.F.

reports to curtail illegal solicitation; and providing that insurers/insureds are not required to pay claims of brokers.

Additional changes were enacted in 2003.[7] These included strengthening health care clinic regulation; requiring agency licensure with the Agency for Health Care Administration (AHCA); requiring all PIP claimants to send a pre-suit demand letter to insurers for unpaid benefits; specifying criteria as to "reasonable" charges for services; strengthening various criminal penalties for PIP fraud; and providing for the repeal of the No-Fault Law on October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session.

In 2006, CS/CS/CS SB 2114, a bill that would have extended the sunset date of the No-Fault Law and made other changes, was passed by the Legislature and subsequently vetoed. The No-Fault Law then sunset on October 1, 2007.[8]

In Special Session C of 2007, the Legislature passed CS/HB 13C, which revived and reenacted the No-Fault Law effective January 1, 2008. The bill, signed into law as ch. 2007-324, L.O.F., limits medical reimbursement to services and care provided by specified health care providers and entities; authorizes insurers to use schedules of maximum charges in calculating reimbursement for medical services, supplies, and care; and provides that an insurer's failure to pay PIP claims as a general business practice is an unfair and deceptive trade practice.

Current Provisions

PIP provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. PIP benefits are payable as follows:

- 80 percent of reasonable medical expenses.
- 60 percent of loss of income.
- Death benefit of $5,000 or the remainder of unused PIP benefits, whichever is less.

PIP provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries. Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:[9]

- Significant and permanent loss of an important bodily function.
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.
- Significant and permanent scarring or disfigurement.
- Death.

Lawsuits for pain and suffering may commence only if the injuries meet these threshold levels.

PIP insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue.[10] Before filing a lawsuit for overdue PIP benefits, the aggrieved person must given the insurer written notice of intent to sue.[11] If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

[7] Chapter 2003-411, L.O.F.
[8] The Motor Vehicle No-Fault Law was repealed pursuant to s. 19, ch. 2003-411, F.S.
[9] Section 627.737, F.S.
[10] Section 627.736(4)(b), F.S.
[11] Section 627.736(10), F.S.

Providers and Entities Eligible for PIP Reimbursement

Pursuant to s. 627.736, F.S., PIP provides medical reimbursement for services and care lawfully provided, supervised, ordered, or prescribed by a licensed physician, osteopath, chiropractor or dentist *or* provided by the following persons or entities:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provides emergency transport and treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child, or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization;
- Licensed health care clinics that:
    - Have a medical director that is a Florida licensed physician, osteopath, or chiropractor;
    - Have been continuously licensed for more than 3 years or are publicly traded corporations; and
    - Provide at least four of the following medical specialties: general medicine; radiography; orthopedic medicine; physical medicine; physical therapy; physical rehabilitation; prescribing or dispensing outpatient prescription medication; or laboratory services.

Charges for Treatment and Services

The No-Fault law sets forth schedules of maximum reimbursement, each of which applies to specified care and services (e.g., emergency transport and treatment). For medical services, supplies, and care not addressed by a specific reimbursement schedule, the no-fault law provides for reimbursement at 80 percent of 200 percent of the physicians schedule of Medicare Part B,[12] developed by the Centers for Medicare and Medicaid Services (CMS). Currently, CMS develops annual fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.[13]

Recent Developments: Case law

Mental and Physical Examinations of PIP Claimants

In *Custer Medical Center v. United Automobile Insurance Co.*,[14] a passenger injured in an automobile accident failed to appear for two medical examinations requested by the insurer. At the time the requests were made, the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Florida Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer on the following grounds: attendance at a medical examination is not a condition precedent to the existence of an automobile insurance policy; a dispute concerning attendance at a medical examination concerns an insured's right to receive "subsequent" PIP benefits pursuant to s. 627.736(7)(b), F.S., under an existing insurance policy, and is not a dispute about the policy's existence; additionally, s. 627.736(7), F.S., provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits. Here, it was not shown that the injured passenger's failure to attend medical examinations constituted an "unreasonable refusal" to submit to examination. Further, the claim sought payment for

[12] Medicare Part B covers doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
[13] The Centers for Medicare and Medicaid Services, "Fee Schedules – General Information," http://www.cms.gov/FeeScheduleGenInfo/ (last visited Jan. 23, 2012).
[14] 62 So.3d 1086 (Fla. 2010).

medical services that had been provided before, and not after, the passenger failed to appear for examination.

Recent Developments: Regulatory

PIP Data Call by Office of Insurance Regulation and Subsequent Report

Early in 2011, the Florida Office of Insurance Regulation (the OIR), pursuant to s. 624.316, F.S., requested data from insurers writing personal automobile lines of business in Florida. The requested data focused on PIP claims associated with policies bearing a Florida PIP endorsement. Thirty-one companies participated in the data call, which covered a scope period from 2006-2010. Twenty-five of the participating companies represented 80.1% of the marketplace based on 2009 Total Private Passenger Auto No-Fault Premiums reported to the National Association of Insurance Commissioners.

On April 11, 2011, the OIR published "Report on Review of the 2011 Personal Injury Protection Data Call."[15] The report noted over the past several years the number of drivers in Florida has remained stable, the number of accidents has decreased, but that the frequency and severity of PIP claims has increased significantly. Other findings include the following:

- The number of PIP claims opened or recorded in 2010 increased by 28% since 2006.
- From 2006-2010, insurers paid $8.7 billion for PIP claims and the number of PIP lawsuits pending at year end in which the insurer was the defendant increased by 387%.
- From 2008 to 2010, PIP benefits paid by insurers increased by 70% ($1.43 billion to $2.37 billion).[16]
- As of 2010, 87% of PIP claims opened originated in South Florida, Tampa/St. Peterburg, Northeast Florida, Southwest Florida, and Central Florida.
- PIP fraud is a significant issue, with Tampa, Miami, Orlando, Hialeah, and West Palm Beach having the highest numbers of staged accidents/questionable claims. Additionally, from July 1, 2007 to April 25, 2010, the number of PIP referrals to the Division of Fraud within the Department of Financial Services increased by more than 60% (from 2,669 referrals to 4,271 referrals).
- In 2010, insurers paid out over $1.04 for every premium dollar collected.
- Based on current trends, a 19% increase in PIP claims paid, a 9% increase in claim severity, and a 29% increase in pure premium can be expected this year.
- Florida exceeds the national average for number of health care provider charges per PIP claim and the average number of procedures per claim.
- For physical medicine and rehabilitation:
    - The median number of procedures per claim increased by 59% from 2006 to 2010.
    - Frequency of procedures increased 22%.
    - The amount billed increased 173% from 2008 to 2010.
    - The number of massages increased 251% from 2007 to 2010, and the amount reimbursed for massages increased 202%.
- For chiropractic treatment:
    - Median number of treatments and duration of treatment decreased by 10% and 13%, respectively, since 2007, and the median frequency has remained constant.
    - The total billed amount for chiropractic manipulative treatment increased 46% since 2007, and total allowed reimbursement increased 23%.

[15] *Available at*: www.floir.com/siteDocuments/PIP_04-08-2011.pdf (last visited Jan. 23, 2012).
[16] Presentation on PIP fraud and overview of findings of the PIP data call report by Insurance Commissioner McCarty at the Aug. 16, 2011 meeting of the Florida Cabinet. Recording of the meeting, *available at*: http://www.myflorida.com/myflorida/cabinet/agenda11/0816/audioindex.html (last visited Jan. 23, 2012).

Personal Injury Protection Working Group and Subsequent Report[17]

In September and October 2011, at a series of three meetings, a PIP Working Group assembled by the Insurance Consumer Advocate (ICA) met to discuss issues of concern in the PIP system. In addition to the ICA, the working group included representatives of various system stakeholders, including hospitals, medical doctors, osteopaths, chiropractors, insurers, and attorneys. The group heard presentations on PIP fraud, results of the OIR's PIP data call, benefits and disadvantages of the current no-fault system, health care clinic licensure (and exemptions from licensure) and fraud, independent medical examinations, and delivery of emergency services, among other matters.

At the conclusion of these meetings, the ICA, in December 2011, published "Report on Florida Motor Vehicle No-Fault Insurance (*Personal Injury Protection*)." The report contains data and information collected from various sources, including the OIR, National Association of Insurance Commissioners, Insurance Research Council, National Insurance Crime Bureau, Mitchell International, Inc., other state agencies, etc. Among the reported findings:

- Strains and sprains were the most serious injury reported by 70% of PIP claimants.[18]
- The number of PIP claimants treated in emergency room settings declined from 57% in 1997 to 54% in 2007.[19]
- In 2010, average charges per PIP claimant (by provider) were lowest for emergency medicine ($1,613). The highest average charges per PIP claimant were by chiropractors ($3,482), acupuncturists ($3,674), and massage therapists ($4,350).[20]
- The number of new massage therapist licenses increased from 2,843 in 2010 to an estimated 4,892 in 2011.
- The percentage of PIP claimants visiting chiropractors increased from 30% in 1997 to 43% in 2007.[21]

Attorney Fee Awards to "Prevailing Claimants" in Litigation Against Insurers

Lodestar Calculation

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court calculates the lodestar, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[22]

In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar:[23]

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.

[17] Meeting materials, presentations and Personal Injury Protection Working Group Report available at: http://www.myfloridacfo.com/ICA/PIPWorkingGroup.htm (last visited Jan. 23, 2012).
[18] Insurance Research Council, "PIP Claiming Behavior and Claim Outcomes in Florida's No-Fault Insurance System," Feb. 2011, based on claims data for 2007.
[19] Analysis updated in Insurance Research Council, "PIP Claiming Behavior and Claim Outcomes in Florida's No-Fault Insurance System," p.11, Feb. 2011.
[20] Analysis based on information secured from Mitchell International Inc., that is representative of approximately 70% of the current Florida PIP insurer marketshare.
[21] Insurance Research Council, " Florida Auto Injury Insurance Claim Environment 2007 Final Report, Feb. 2007.
[22] The federal lodestar approach to determining fee awards was adopted by the Florida Supreme Court in *Florida Patient's Compensation Fund v. Rowe*, 472 So.2d 1145 (Fla. 1985).
[23] *See* Rule 4-1.5(b) of the Rules Regulating the Florida Bar.

- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

Contingency Risk Multiplier

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the lodestar in determining the fee award.[24] For example, if the lodestar were $20,000 and the court determined it appropriate to apply a contingency risk multiplier of 2.5, the fee award would be $50,000 ($20,000 lodestar x 2.5).

The Florida Supreme Court, in *Florida Patient's Compensation Fund v. Rowe*,[25] authorized the use of contingency risk multipliers in personal injury cases on two grounds:

- It provides personal injury claimants with increased access to courts.
- Since attorneys working on a contingency fee basis are not paid if they do not prevail, they must charge more for their services than an attorney who is guaranteed payment.

Subsequently, in *Standard Guaranty Insurance Co. v. Quanstrom*,[26] the Court clarified that use of a contingency risk multiplier was not mandatory, but was within the trial court's discretion.

In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[27]

Currently, there is a split of authority between the First and Fifth District Courts of Appeal with respect to the evidence required to support the use of a contingency risk multiplier in calculating a fee award under s. 627.428, F.S. In *Progressive Express Insurance Co. v. Schultz*,[28] the 5th DCA held that use of a contingency risk multiplier in a PIP action was improper because the policyholder did not testify that he had any difficulty obtaining legal representation, there was no evidence presented on the issue, and the lawsuit was essentially a straightforward contract case involving $1,315. In *Massie v. Progressive Express Insurance Co.*,[29] the issue before the 1st DCA was whether use of a contingency risk multiplier was proper when the PIP claimant did not testify that she had difficulty obtaining counsel, but expert testimony was offered that the claimant would have had such difficulty without the opportunity for a multiplier. On direct appeal, the Circuit Court reversed the trial judge, relying on *Schultz,* holding that the use of a multiplier was improper, and the claimant petitioned for certiorari review. Based on its own precedent, the 1st DCA granted the petition, quashed the order on direct appeal, and affirmed the trial court's use of a contingency risk multiplier based on expert testimony.

Effect of Bill

Motor Vehicle Crash Reports

The bill provides for a single crash report form, rather than a long-form report and a short-form report. In addition to other required information, a completed form must clearly identify the driver of each vehicle, the passengers, and the vehicle in which each passenger was traveling. For motor vehicle accidents that result in death, personal injury, or involve a driver who leaves the accident scene or is driving under the influence, the crash report must be submitted to the Florida Department of Highway

[24] *Standard Guaranty Insurance Co. v. Quanstrom*, 555 So.2d 828 (Fla. 1990).
[25] 472 So.2d 1145 (Fla. 1985).
[26] 555 So.2d 828 (Fla. 1990).
[27] *See Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[28] 948 So.2d 1027 (Fla. 5th DCA 2007).
[29] 25 So.3d 584 (Fla. 1st DCA 2009).

Safety and Motor Vehicles. All other crash reports are to be maintained by the law enforcement officer's agency.

No-Fault Motor Vehicle Insurance

The Florida Motor Vehicle Emergency Care Coverage Law (ECC Law), a no-fault motor vehicle insurance system, is created to replace PIP, effective for no-fault insurance policies issued or renewed on and after October 1, 2012. The ECC Law provides a significantly different approach to no-fault insurance, particularly as to the scope of injuries covered, but retains, with varying degrees of change, many aspects of the current no-fault system (demand letters, schedule of maximum charges, etc.). The bill provides that it is the Legislature's intent that the provisions, schedules, and procedures of the ECC Law be given full force and effect, regardless of their inclusion in an insurer's forms, on the effective date of the bill.

No-fault insurers will continue to use current forms and rates for all policies issued or renewed before October 1, 2012. All forms and rates for policies used or renewed on or after this date must reflect the provisions of the ECC Law and must be approved by the OIR prior to being used.

The following provides an overview of significant features of the ECC Law.

Mandatory Insurance Coverage

Florida motorists are required to secure and maintain $10,000 of no-fault, emergency care coverage insurance (ECC insurance) and $10,000 of property damage liability insurance. Insurers may not require motorists to purchase other types of motor vehicle insurance or coverage in amounts greater than that required by law.

ECC Insurance

ECC insurance provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. ECC insurance benefits are payable as follows.

- 80 percent of reasonable medical expenses for:
    1. Emergency transport and treatment rendered by a licensed ambulance provider within 24 hours after the motor vehicle accident.
    2. *"Emergency services and care"* rendered within 72 hours after the motor vehicle accident in a licensed hospital.
    3. Services and care rendered when an insured is admitted to a hospital within 72 hours after the motor vehicle accident.
    4. Services and care rendered to an insured who is determined more than 72 hours after the motor vehicle accident to have an "*emergency medical condition*" related to the initial diagnosis and arising from the motor vehicle accident.
    5. If the insured receives services and care pursuant to 2., 3., or 4., subsequent services and care directly related to the medical diagnosis arising from the motor vehicle accident, subject to the following:
        a) The diagnosis must be rendered in a licensed hospital and rendered by a physician licensed under chapter 458, F.S., or a licensed osteopathic physician; and
        b) The care and services must be rendered by a physician licensed under chapter 458, a licensed osteopathic physician, a licensed dentist, a physician assistant licensed under chapter 458 or 459, F.S., or a licensed advanced registered nurse practitioner.
- 60 percent of loss of income.
- Death benefit of $5,000 or the remainder of unused ECC benefits, whichever is less.

“Emergency services and care” means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exits, and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

“Emergency medical condition” is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to patient health, including a pregnant woman or fetus.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman, an emergency medical condition exists:

- When there is inadequate time to effect safe transfer to another hospital prior to delivery;
- When a transfer may pose a threat to the health and safety of the patient or fetus; or
- There is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

For purposes of the ECC law, a medical diagnosis that an emergency medical condition exists is presumed to be correct, unless rebutted by clear and convincing evidence to the contrary.

ECC insurance provides the policyholder with immunity from liability for covered injuries, for economic damages (medical expenses) up to the $10,000 policy limits, and for non-economic damages (pain and suffering). The immunity provision protects the insured, for covered injuries, from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:

- Significant and permanent loss of an important bodily function.
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.
- Significant and permanent scarring or disfigurement.
- Death.

Lawsuits for pain and suffering may commence for covered injuries only if the injuries meet these threshold levels.

Payment of Benefits

ECC insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue. Before filing a lawsuit for overdue ECC benefits, the aggrieved person must give the insurer written notice of intent to sue. If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

If an insurer has reasonable belief that a fraudulent insurance act has been committed and reports its suspicions to the Division of Insurance Fraud, the 30-day payment period is tolled as to any portions of the claim reported for investigation. The insurer, within 30 days of receipt of written notice of a covered loss and the amount of the loss, must notify the insurer in writing that the claim is being investigated for fraud. Within 30 days of receiving notice from the Division of Insurance Fraud that a claim has been investigated and no criminal action will be recommended, the insurer must pay the claim with interest. Persons or entities who, in good faith, report suspected fraud or release information in furtherance of a fraud investigation are immune from civil and criminal liability for the reporting or release of such information.

ECC benefits are not due or payable to or on behalf of an insured, claimant, provider, or attorney, if such person has:

- Submitted a false material statement, document, record, or bill.
- Submitted false material information.
- Otherwise committed or attempted to commit a fraudulent insurance act.

Persons who commit such acts are precluded from receiving any ECC benefits relating to the claim, including payment for bills or services, regardless of whether a portion of the claim is legitimate. Medical providers cannot be denied payment for services rendered solely due to the misconduct of another person.

Medical Reimbursement under the ECC Law

Medical providers and entities may charge the insurer and injured party only a reasonable amount for services and care rendered. Payments made by insurers pursuant to the schedule of maximum charges are considered reasonable. If a provider bills a lesser amount, and the insurer pays the amount billed, the payment is also considered reasonable. Insurers that provide reimbursement under the schedule of charges may use all Medicare coding policies and CMS payment methodologies, including applicable modifiers to determine the appropriate amount of reimbursement for medical services, supplies, or care.

The ECC Law permits reimbursement at 80% of the following schedule of maximum charges:

- For emergency transport and treatment by licensed providers, 200 percent of Medicare.
- For emergency services and care provided by a licensed hospital, 75 percent of the hospital's usual and customary charges.
- For emergency services and care provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.
- For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.
- For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.
- For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For medical supplies, care, and services rendered by clinical laboratories, 200 percent of the allowable amount under Medicare Part B. For durable medical equipment, the amount contained in the Durable Medical Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13, F.S., and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

In calculating reimbursements under the schedule of maximum charges, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation that was in effect as of March 1st of the year in which the services, supplies, or care was rendered, and applies until March 1st of the following year, regardless of any subsequent changes to such fee schedule or payment limitation. However, the reimbursement amount may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

Upon receipt of notice of an accident that is potentially covered by ECC insurance, an insurer must reserve, and hold for 30 days, $5,000 of ECC benefits for payments to specified health care providers who provide emergency care coverage.

Insurers are authorized to request and conduct onsite physical reviews and examinations of the treatment locations and medical equipment of medical providers and entities that submit claims for payment of ECC benefits.

Examinations Under Oath and Compliance with Policy Terms

All insureds and assignees of ECC policy benefits, including medical providers, are required to comply with all policy terms, including submitting to examinations under oath (EUO). Compliance with policy terms by insureds and assignees is a condition precedent to such person's eligibility for policy benefits. Before requesting that an assignee participate in an EUO, the insurer must request the information sought in writing. EUOs may be recorded.

When an insurer requests that a medical provider submit to an EUO, the provider must produce individuals identified in the request or, or if no person is identified, then the persons who have the most knowledge of the issues identified by the insurer. Medical providers and persons produced in response to the insurer's request are entitled to reasonable compensation for attending an EUO, which must be paid prior to the EUO. Such compensation is to be based on good faith estimates of the hourly rate for the health care provider and other persons to be examined and the time required to conduct the EUO. If additional time is needed for the examination, the insurer must pay additional compensation within 15 days to each person that completes the EUO. Insurers that, as a general business practice, request EUOs of assignees without a reasonable basis commit an unfair and deceptive trade practice.

Insurers must coordinate with claimants for ECC benefits to ensure an appropriate time and location for the EUO. A claimant's failure to agree to attend an EUO after an insurer presents two documented offers of a reasonable time and location, allows the insurer to suspend benefits, until the claimant agrees to submit, and actually submits to, the EUO.

Examinations (Mental or Physical) of the Insured

When an insured unreasonably refuses to submit to or fails to appear at an examination (mental or physical) requested by the insurer, the ECC insurer is not liable for subsequent ECC benefits. An insured's refusal or failure to appear for two examinations (mental or physical) is presumed to be an unreasonable refusal or failure to submit to examination. The presumption, however, is rebuttable, and may be overcome by the claimant upon showing that refusal or failure to attend was not unreasonable.

Limitations on Attorney Fee Awards

The use of contingency risk multipliers in calculating fee awards in no-fault ECC disputes is prohibited. Fee awards in no-fault litigation are limited to the lesser of the actual fee incurred based upon a rate for attorney services not to exceed $200 per billable hour or:

- For any disputed amount of less than $500, 15 times any disputed amount recovered by the attorney, limited to $5,000.
- For any disputed amount of $500 or more and less than $5,000, 10 times any disputed amount recovered by the attorney, limited to a total of $10,000.
- For any disputed amount of $5,000 or more and up to $10,000, 5 times any disputed amount recovered by the attorney, limited to a total of $15,000.

Attorneys fee awards in a class action are limited to the lesser of $50,000 or three times the total of any disputed amount recovered in the class action proceeding.

Fees incurred in litigating or quantifying the amount of fees due to the prevailing party under the ECC Law are not recoverable.

These limitations on attorney fee awards are effective upon the bill becoming law.

B. SECTION DIRECTORY:

Section 1. Amends s. 316.066, F.S., effective May 1, 2012, relating to motor vehicle crash report forms.

Section 2. Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.

Section 3. Creates s. 627.748, F.S., providing for ss. 627.748-627.7491, F.S., to be referred to as the Florida Motor Vehicle No-Fault Emergency Care Coverage Law (ECC Law).

Section 4. Creates s. 627.7481, F.S., providing the purposes of the ECC Law.

Section 5. Creates s. 627.74811, F.S., providing the effect of the law on ECC policies.

Section 6. Creates s. 627.7482, F.S., providing definitions.

Section 7. Creates s. 627.7483, F.S., providing for required security for Florida motorists.

Section 8. Creates s. 627.7484, F.S., providing for proof of security.

Section 9. Creates s. 627.7485, F.S., providing required benefits under ECC policies.

Section 10. Creates s. 627.7486, F.S., providing tort exemption for injuries under the ECC law.

Section 11. Creates s. 627.7487, F.S., providing for optional deductibles under ECC policies.

Section 12. Creates s. 627.7488, F.S., providing for a notification of rights to insureds under the ECC Law.

Section 13. Creates s. 627.7489, F.S., requiring mandatory joinder of certain ECC claims.

Section 14. Creates s. 627.749, F.S., providing insurer’s right to reimbursement for ECC benefits under specified circumstances.

Section 15. Creates s. 627.7491, F.S., providing for application of the ECC Law.

Sections 16 to 49. Amends ss. 316.646, 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032, 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234, F.S., to conform and correct cross-references.

Section 50. Directs the Division of Statutory Revision to replace the phrase "the effective date of this act" wherever it occurs in this bill with the date the bill becomes law.

Section 51. Providing an effective date of October 1, 2012, except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Indeterminate. Florida imposes a 1.75% premium tax on the gross insurance premiums collected by every insurance company. The tax is subject to numerous deductions. The tax is paid into the General Revenue Fund. In FY 2010-11, premium taxes of $482.5 million were paid into the General Revenue Fund. This sum represents the premium tax from all forms of insurance, it is unknown how much premium tax results from PIP coverage. It is anticipated that this bill will lower insurance premiums and correspondingly decrease collections of the insurance premium tax. The potential fiscal loss to the state is unknown. It is also possible that consumers may purchase additional insurance offsetting some of this loss.

2. Expenditures:

The bill will create workload for the Office of Insurance Regulation (OIR) and the Department of Financial Services (DFS). OIR will need to conduct ratemaking for the new ECC policies. DFS will need to conduct rulemaking to implement the policies and create the related forms.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The Department of Highway safety and Motor Vehicles reports it is unclear what impact the new traffic form requirements will have on local law enforcement agencies. The use of “long form” traffic accident reports by various local law enforcement agencies may require more time per accident investigation.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that ECC policies provide a narrower range of coverage and curtail fraud in the no-fault system, the ECC Law will lower the premiums paid by Florida motorists for no-fault motor vehicle insurance. Correspondingly, this bill will result in some medical providers not being paid from a traditional source, which may result in shifting some medical costs to health insurance providers, shifting some medical costs to individuals, and lower utilization of providers where individuals are unable or unwilling to pay for such medical care.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or, reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

Florida's Constitution provides that "[t]he courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay."[30] No Florida court has found a statutory limit on attorneys fees unconstitutional under this provision, but a limit has the *potential* of being found unconstitutional if such limit reaches the point that attorneys are unwilling to represent claimants because the limits are too low in relation to the time required to work on the case.

For instance, Florida has enacted attorneys fee limits applicable to worker's compensation cases.[31] One district court upheld the limits based on a lack of evidence of their impact, but stated that it would hear the issue again if a party could present sufficient evidence "that the statute has unduly burdened a claimant's ability to retain counsel in order to secure benefits, or that the statute limits the types of benefits a claimant is authorized to pursue under [the statute]."[32]

B. RULE-MAKING AUTHORITY:

The bill requires rulemaking by several agencies. DFS will likely need to adopt rules to implement the bill and adopt related forms.

The Department of Health, is required to develop by rule a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by emergency care coverage benefits under this section.

The Financial Services Commission is required to adopt by rule a standard disclosure and acknowledgment form. The commission is also required to adopt by rule a form for the notification of insureds of their right to receive emergency care coverage.

It appears adequate rulemaking is provided for the required rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 11, 2012, the Insurance & Banking Subcommittee considered and adopted a proposed committee substitute substantially changing the bill from one modifying PIP to one substituting ECC for PIP. This analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.

[30] Article I, s. 21, Florida Constitution.
[31] Section 434.34, F.S.
[32] *Lundy v. Four Seasons Ocean Grand Palm Beach*, 932 So.2d 506, 510 (Fla. 1st DCA 2006).