The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Committee

BILL:	CS/CS/SB 1860
INTRODUCER:	Budget Committee, Banking and Insurance Committee, and Senator Negron
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	March 2, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Fav/CS**
2.	Betta, Knudson	Rhodes	BC	**Fav/CS**
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill amends the Florida Motor Vehicle No-Fault Law. The bill primarily amends the laws governing Personal Injury Protection (PIP) medical benefits under the No-Fault law and laws related to motor-vehicle insurance fraud. The major changes enacted by the bill are as follows.

PIP Medical Benefits

The bill eliminates PIP medical benefit reimbursement for massage as defined in section 480.033, Florida Statutes, and acupuncture as defined in section 457.102, Florida Statutes

Payment of PIP Benefits

The bill makes the following changes regarding payment of PIP benefits:

- Insurers must give priority to the payment of the $5,000 death benefit over other PIP benefits.
- Expands the requirement to reserve $5,000 of PIP benefits to physicians or dentists providing emergency treatment to include hospitals.

- Insurers must repay the full amount of benefits paid by the Medicaid program within 30 days after receipt of notice.
- An insurer that rejects a claim or pays only a portion of a claim due to an alleged error in the claim must include with the rejection or partial payment an itemized specification or explanation of benefits of the specified error. The claimant then has 15 days to submit a revised claim. The insurer has 15 days after the resubmitted or revised claim to issue payment.
- Insurers must maintain a log of PIP benefits paid by the insurer to each insured. The insurer must provide the payment log within 30 days after receiving a request for the log from the insured or an assignee.
- If there is a dispute between an insurer and an insured or assignee and policy limits are reached, the insurer must notify the insured or assignee that policy limits have been reached within 15 days.
- Hospitals; insureds claiming lost wages; and physicians, osteopathic physicians, dentists who provide emergency services and care or hospital inpatient care are exempted from the requirement to provide an insurer with a demand letter prior to litigating a PIP dispute.
- Specifies that a demand letter is not deficient for containing calculation errors or not taking payments into account, and directs courts to evaluate a demand letter's compliance using the standard of substantial compliance. If a demand letter is found deficient after a lawsuit has commenced, the insured or assignee may abate the lawsuit and correct the deficiency. The insurer must specify in its response to the demand letter each deficiency the insurer is claiming or it waives any deficiencies found in the notice.

PIP Medical Fee Schedule

The bill makes the following changes regarding the content and application of the PIP medical fee schedule:

- Specifies that the Medicare fee schedule in effect on January 1 will apply to all medical care and supplies rendered in that calendar year.
- Effective July 1, 2012, an insurer may only limit reimbursement pursuant to the PIP fee schedule if the insurer provides notice at the issuance or renewal of the auto insurance policy that the insurer will provide reimbursement pursuant to the fee schedule.
- Authorizes insurers to use Medicare coding policies and payment methodologies so long as they do not constitute a utilization limit.
- Specifies that the Medicare Part B fee schedule applies to services, supplies and care provided by ambulatory surgical centers and clinical laboratories under the PIP fee schedule.
- Specifies that durable medical equipment is reimbursed at 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B.

Mandatory Clinic Licensure; Exceptions

All entities providing health care services must be licensed clinics in order to receive PIP reimbursement except for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (chapters 458 and 459, Florida Statutes),

licensed dentists, and licensed chiropractors or jointly owned by such practitioners and specified family members.

Crash Reports

The bill requires all crash reports and the drivers exchange of information form to indentify all vehicles and their passengers involved in a crash. The bill also requires law enforcement to submit all crash reports to the Department of Highway Safety and Motor Vehicles.

Clinic Licensure Insurance Fraud

The bill defines as a false and fraudulent insurance claim under section 817.234, Florida Statutes, presenting PIP claims to an insurer that a person knows are made on behalf of a payee that knowingly submitted a false, misleading, or fraudulent document when applying for clinic licensure, a clinic licensure exemption, or demonstrating compliance with the Health Care Clinic Law. Such acts are subject to investigation by the Division of Insurance Fraud. The AHCA clinic licensure application and exemption forms will provide notice of criminal liability for committing such acts.

Health Care Practitioner License Suspension

A licensed health care practitioner found guilty of insurance fraud under section 817.234, Florida Statutes, will have his or her licensed revoked for five years and may not receive PIP reimbursement for ten years.

Electronic Records

The bill permits electronic transmission of all notices, documents, communications and transmissions required or authorized under the No-Fault law. It deletes the requirement that electronic transmission may only occur if all parties expressly agree. This portion of the bill is effective December 1, 2012.

Auto Insurance Fraud Direct Support Organization –

The bill creates a non-profit direct support organization designed to receive money from private persons that will fund state agencies, state attorneys' offices, and the statewide prosecutor for the purposes of preventing, investigating, and prosecuting motor vehicle insurance fraud. The board of directors consists of the Chief Financial Officer (CFO), who serves as the chair, and eight appointed members.

PIP Data Call

The bill requires the Office of Insurance Regulation (OIR) to perform a comprehensive PIP data call and publish the results by January 1, 2015. The data call will analyze the impact of the act's reforms on the PIP insurance market.

The bill is effective July 1, 2012, except as otherwise expressly provided.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.9905, 400.991, 626.989, 626.9894, 627.736, and 817.234.

This bill creates section 626.9895, Florida Statutes.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law[1], owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault.[2] This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold.[3] In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both PIP and property damage liability (PD) insurance.[4] The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person.[5] PIP coverage provides reimbursement for 80 percent of reasonable medical expenses,[6] 60 percent of loss of income,[7] 100 percent of replacement services,[8] for bodily injury sustained in a motor vehicle accident, without regard to fault. The PD coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.[9]

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[10] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provides emergency transportation or 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; or

[1] Sections 627.730-627.7405, F.S.
[2] See s. 627.731, F.S.
[3] Section 627.737, F.S.
[4] See sections 324.022, F.S. and 627.733, F.S.
[5] Section 627.736(1), F.S.
[6] Section 627.736(1)(a), F.S.
[7] Section 627.736(1)(b), F.S.
[8] Id.
[9] Section 627.736(1)(c), F.S.
[10] Chapter 2007-324, L.O.F.

- Licensed health care clinics that meet specified criteria.[11]

Medical Fee Limits for PIP Reimbursement

Section 627.736(5), F.S., authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B; and
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation.[12] Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent copayment) or for amounts that exceed maximum policy limits.[13]

Motor Vehicle Insurance Rates

Motor vehicle insurance rates have increased dramatically since the 2008 re-enactment of the No-Fault law. The OIR provided committee staff a summary of the cumulative motor vehicle rate increases implemented from January 1, 2009, to February 1, 2012, by the five insurance carriers with the largest market share in the Florida marketplace.[14]

Coverage	State Farm Mutual	GEICO General[15]	Progressive American[16]	Progressive Select[17]	Allstate Insurance
PIP	**49.7%**	**87.6%**	**62.8%**	**50.2%**	**35.1%**

[11] See sub-subparagraphs 1-5 of s. 627.736(1)(a), F.S.
[12] Section 627.736(5)(a)4., F.S.
[13] Section 627.736(5)(a)5., F.S.
[14] Data supplied by the Office of Insurance Regulation, based on data submitted in the Rate Collection System as of February 1, 2012.
[15] Includes two pending filings as of February 1, 2012.
[16] Includes one pending filing as of February 1, 2012.
[17] Includes one pending filing as of February 1, 2012

PD	40.0%	-0.9%	-3.9%	5.9%	29.6%
BI	40.0%	49.0%	33.2%	33.9%	46.3%
UM	52.4%	-3.2%	50.2%	75.4%	-7.4%
Med Pay	-3.8%	5.9%	7.9%	19.5%	23.1%
Collision	-15.9%	-22.1%	-20.7	-14.8%	-24.7%
Comp.	-7.2%	-18.0%	-28.2%	-21.7%	-26.3%
TOTAL	**26.0%**	**19.6%**	**19.2%**	**19.2%**	**11.5%**

These premium increases have occurred despite data obtained from the Department of Highway Safety and Motor Vehicles showing decreases in:

- The number of licensed drivers in Florida (15,579,603 in 2008 to 15,553,387 in 2010).
- The frequency of auto crashes in Florida (1.56 crashes per 100 licensed drivers in 2008 to 1.52 crashes per licensed driver in 2010).
- The number of crash-related injuries in Florida (199,658 in 2008 to 195,104 in 2010.

Though the number of drivers, crashes, and injuries decreased from 2008 to 2010, the direct incurred losses of insurers dramatically increased from approximately $1.475 billion in 2008 to approximately $2.298 billion in 2010, an increase of approximately 55.8 percent.

The foregoing rate increases led the OIR to promulgate a PIP data call[18] and issue a report on its findings in April 2011.[19] The OIR report found large increases in medical provider charges, which increased from approximately $10,000 per claim in 2007 to $12,000 per claim in 2010.[20] The average number of procedures per claim greatly increased from less than 70 per claim in 2007 to over 100 per claim in 2010.[21] The average provider charge per procedure showed a slight decrease during 2008-2010, which is unsurprising given the enactment of the PIP medical fee schedule. The OIR data call indicates that the large loss increases insurers have incurred from 2008-2010 are due largely to sizeable increases in the number of treatments provided per PIP claim.

In December 2011, the Insurance Consumer Advocate issued a Report on Florida Motor Vehicle No-Fault Insurance. The report was based largely on information gathered through a Personal Injury Protection Working Group (Working Group) convened in August 2011 by the Consumer Advocate at the request of the CFO to research and analyze the No-Fault system and why losses and premiums are rapidly increasing.

The Consumer Advocate's report found rapid growth in the number of procedures billed from 2005 to 2010. The largest increases were found for "Massage, 15 minutes" and "Therapeutic Exercise, 15 minutes" which each increased by approximately 2.6 million units from 2005 to 2010.[22] Specifically, "Massage, 15 minutes" increased from approximately 1.42 million units in

[18] Thirty-one companies participated in the data call, constituting approximately 80 percent of the private passenger No-Fault premium market in Florida.
[19] OIR Report on Review of the 2011 Personal Injury Protection Data Call (April 11, 2011).
[20] See id. at pg. 13
[21] See id.
[22] Office of the Insurance Consumer Advocate Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection, pg. 23 (December 2011).

2005 to approximately 4.05 million units in 2010, while therapeutic exercise increased from approximately 713,000 units in 2005 to 3.36 million units in 2010. These two procedures are now the two most commonly billed procedures in the PIP system.

The Consumer Advocate's report also presented data on increases in the average charge per claimant by provider. Average charges by massage therapists saw the greatest increase, increasing from $2,887 in 2005 to $4,350 in 2010.[23] The second largest increase was by acupuncturists, whose average charge increased from $2,754 in 2005 to $3,674 in 2010.[24] In contrast, the average charge by an orthopedic surgeon only increased $126 from 2005-2010, billing on average the comparatively smaller figure of $2,810 in 2010.[25] As of 2010, massage therapists and acupuncturists issue the largest average charges of any medical provider that bill within the PIP system.[26]

Motor Vehicle Insurance Fraud

Over the past five years, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (division)[27] nearly doubled from Fiscal Year 2008-2009 (776)[28] to Fiscal Year 2010-2011 (1,416).[29] The division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during Fiscal Year 2007-2008[30] to 6,699 in Fiscal Year 2010-2011.[31] Florida led the nation in staged motor vehicle accident "questionable claims"[32] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[33]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee issued a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the division during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 hundred PIP fraud referrals received by the division during the 2009-2010 fiscal year. Given this fact, the following description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

[23] See id. at pg. 21.
[24] See id.
[25] See id.
[26] See id.
[27] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[28] Florida Department of Financial Services Division of Insurance Fraud Statistical Report: Fiscal Year 2008-2009, pg. 12.
[29] Florida Department of Financial Services Division of Insurance Fraud Annual Report: Fiscal Year 2010-2011, pg. 30.
[30] See fn. 25.
[31] See fn. 26.
[32] See fn. 19 at pg. 29. The NICB defines a "questionable claim" as one in which indications of the behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[33] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies with law enforcement

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the division have identified the following as sources of motor vehicle insurance fraud:

- Ease in obtaining exemptions from the Health Care Clinic Law.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,[34] that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers. A dissent in the case stated that the policy required the medical provider to submit to an examination under oath because the State Farm policy clearly stated that the medical provider must submit to an EUO under the State Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an

[34] *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Demand Letter

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of an intent to initiate litigation. The notice must include an itemized statement detailing the exact amount and type of treatment asserted to be due. If the insurer pays the claim within 30 days (with interest and penalty) after receiving the demand letter then no action may be brought against the insurer. A suit may not be filed to obtain benefits and potentially collect attorney's fees until the end of this 30-day period.

Florida Uniform Crash Reports

Section 316.066, F.S., provides that a Florida Traffic Crash Report-Long Form must be completed and submitted to the Department within ten days after an investigation by every law enforcement officer who, in the regular course of duty, investigates a motor vehicle crash that resulted in death or personal injury, that involved a violation of s. 316.061(1), F.S., or s. 316.193, F.S., and in which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if the action is appropriate, in the officer's discretion. For every crash for which a Florida traffic crash report long form is not required by s. 316.066, F.S., the law enforcement officer may complete a short form crash report or provide a short form crash report to be completed by each party involved in the crash.

Health Care Clinic Licensure

The Health Care Clinic Licensure Act (ss. 400.990-400.995, F.S.) was enacted by the 2003 Legislature for the purpose of preventing cost and harm to consumers by providing for the licensure, establishment and enforcement of basic standards for health care clinics. The definition of a health care "clinic" is expansive: "an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider."[35] However, the statute contains a multitude of exemptions from licensure. For instance, an entity owned by a Florida-licensed health care practitioner or by a Florida-licensed health care facility is exempt from the clinic licensure requirements. Furthermore, clinic exemptions are voluntary and the Agency for Health Care Administration (AHCA) has no statutory authority to verify that an entity qualifies for an exemption as claimed.

An applicant[36] for clinic licensure must submit to and pass a level two background screening pursuant to s. 435.04, F.S., which requires taking fingerprints of each applicant and conducting a statewide criminal history check through the Department of Law Enforcement (FDLE) and national criminal history check through the Federal Bureau of Investigation (FBI). AHCA also reviews the finances of the proposed clinic and inspects the facility to verify that the proposed clinic complies with licensure requirements.

[35] Section 400.9905(4), F.S.
[36] An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.

Direct Support Organizations

A direct service organization (DSO) collects funds through grants, donations and other sources, and distributes them to entities that will use the funds to further a legislative purpose. Florida's nondelegation doctrine derives from Article II, Section 3 of the Florida Constitution and prohibits one branch of government from encroaching on another branch's power and also prohibits any branch from delegating its constitutionally assigned powers to another branch.[37] Accordingly, a DSO cannot exceed its grant of statutory authority. Additionally, as a statutorily created organization, the DSO is subject to the Government in the Sunshine law under ch. 119, F.S.[38] Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within five months after the end of the fiscal year.[39]

III. Effect of Proposed Changes:

Traffic Crash Reports

Section 1 amends s. 316.066, F.S., to require all crash reports and the drivers exchange of information forms to indentify all passengers involved in the crash and the vehicle the drivers and passengers were in. The bill also requires law enforcement to submit all crash reports to the Department of Highway Safety and Motor Vehicles (DHSMV). The bill expands the types of crashes where the use of a long-form crash report is required to include crashes that render a vehicle inoperable to the extent that a wrecker is required to remove it from the accident scene and crashes involving a commercial motor vehicle. The bill also specifies that a short-form report or a driver's exchange of information form must be completed for all crashes on a public roadway for which a long-form report is not required. Drivers involved in accidents where a law enforcement report is not required must submit a report to the DHSMV within 10 days after the crash on a DHSMV-approved form.

Section 10 provides a technical conforming change to s. 316.065, F.S., necessitated by the substantive amendment to s. 316.066, F.S.

Health Care Clinic Related Insurance Fraud

Submitting PIP Claims on Behalf of Fraudulent Clinics

Section 9 amends s. 817.234(1)(a), F.S., to define as insurance fraud presenting a claim for PIP benefits on behalf of an entity while knowing that the entity knowingly submitted a false, misleading, or fraudulent application or document when applying for health care clinic licensure, licensure exemption, or demonstrating compliance with the Health Care Clinic Law. Insurance

[37] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla. 2005)
[38] *See* s. 119.011(2), F.S. (defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, *or other separate unit of government created or established by law including, for the purposes of this chapter*, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, *and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency*.") (emphasis added). See also *Crespo v. Florida Entertainment Direct Support Organization, Inc*., 674 So.2d 154 (Fla. 3rd DCA 1996).
[39] *See* ss. 11.45, 215.981, F.S.

fraud under s. 817.234, F.S., is a felony offense and fraud related to motor vehicle insurance is also subject to monetary civil penalties.

Notice of Health Care Clinic Licensure Insurance Fraud

Section 3 amends s. 400.991, F.S., to require all AHCA forms for clinic licensure or exemption to include a notice of criminal liability. The notice states that submitting a false, misleading, or fraudulent document when applying for clinic licensure, clinic licensure exemption, or demonstrating compliance with the Health Care Clinic Law (part X, ch. 400, F.S.), with the intent to provide services or seek reimbursement under the No-Fault law is a fraudulent insurance act subject to investigation by the division pursuant to s. 626.989, F.S. The notice also states that presenting a claim for PIP benefits knowing that the payee knowingly submitted a fraudulent clinic application or document commits insurance fraud pursuant to s. 817.234, F.S.

Clinic-Related Insurance Fraud Subject to Investigation by Division of Insurance Fraud

Section 4 amends s. 626.989, F.S., which defines acts that are subject to investigation by the Division of Insurance Fraud as a "fraudulent insurance act." Expansion of the definition is intended to expand the ability of the division to investigate health care clinic fraud. A "fraudulent insurance act" is:

- The knowing submission of a false, misleading, or fraudulent application or document when applying for health care clinic licensure, a licensure exemption, or demonstrating compliance with the Health Care Clinic Law with the intent to use the license, exemption, or compliance to provide services or seek PIP reimbursement; or
- Presenting a claim for payment or benefits under a PIP insurance policy while knowing the payee knowingly submitted a false, misleading, or fraudulent application or document when applying for a clinic license, exemption, or demonstrating compliance with the Health Care Clinic Law.

Clinic Licensure Required to Receive PIP Reimbursement

Section 2 amends s. 400.9905, F.S., to require that all entities providing health care services be licensed clinics in order to receive PIP reimbursement except for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (ch. 458, F.S. and ch. 459, F.S.), licensed dentists, and licensed chiropractors or jointly owned by such practitioners and specified family members.

Motor Vehicle Fraud Direct Support Organization

Section 5 amends s. 626.9894, F.S., to specify that the balance of monies deposited in the Insurance Regulatory Trust Fund from the DSO at the end of a fiscal year may be used to fund the division. The DFS may also request the appropriation of such funds for insurance anti-fraud purposes.

Section 6 creates s. 626.9895, F.S., which establishes a non-profit direct support organization (DSO) designed to receive money from private persons and entities for the purposes of

preventing, investigating, and prosecuting motor vehicle insurance fraud. The DSO is authorized to conduct programs and activities, raise money and invest such monies, and make grants and expenditures that directly or indirectly benefit specified governmental entities to exclusively advance the DSO's purposes.

Grants and expenditures made by the DSO may fund the salaries and benefits of motor vehicle insurance fraud investigators, prosecutors, and support personnel. Such monies and expenditures cannot interfere with prosecutorial independence or create conflicts of interest which threaten the success of prosecutions, nor may they be used for lobbying. Contributions from insurers shall be allowed as an appropriate business expense for regulatory purposes. The DSO is subject to an annual financial audit pursuant to s. 215.981, F.S.

The DSO is governed by an eleven member board of directors, made up as follows:

- The CFO (or designee) who serves as chair.
- Two state attorneys. The CFO and Attorney General each have one appointment.
- Two representatives of motor vehicle insurers appointed by the CFO.
- Two representatives of local law enforcement agencies. The CFO and Attorney General each have one appointment.
- Two representatives of health care providers who regularly make PIP claims. The President of the Senate and Speaker of the House of Representatives each has one appointment.
- A private attorney with experience representing PIP claimants, appointed by the President of the Senate.
- A private attorney with experience representing PIP insurers, appointed by the Speaker of the House of Representatives.

The DSO will operate under a written contract with the division. The division will have approval authority of the DSO's articles of incorporation and bylaws. The DSO must submit an annual budget to the division for its approval. The DSO will also be required to obtain an annual certification from the division that it is complying with the terms of the contract and operating in accordance with the DSO's purposes. The DFS may authorize the DSO to use division facilities without charge.

Personal Injury Protection Benefits

Section 7 amends s. 627.736, F.S., regarding PIP No-Fault insurance in the following ways:

PIP Required Benefits [s. 627.736(1), F.S.]

Under current law, subsection (1) of s. 627.736, F.S., details the required personal injury protection benefits, which must include at least $10,000 in medical, disability, and death benefits (the latter of which can be up to $5,000 of the total $10,000 benefit). The bill amends this subsection in the following ways:

Massage and Acupuncture Not Reimbursable

The bill eliminates PIP medical benefit reimbursement for massage as defined in s. 480.033, F.S., and acupuncture as defined in s. 457.102, F.S.

Death Benefits

Insurers must give priority to the payment of the $5,000 death benefit over other PIP benefits.

Payment of Benefits [s. 627.736(4), F.S.]

Under current law, subsection (4) of s. 627.736(4), F.S., contains requirements related to the payment of No-Fault benefits that insurers and claimants must comply with. Paragraph (b) of this subsection requires insurers to pay personal injury protection benefits within 30 days after receiving written notice of a covered loss. The bill makes the following changes related to the payment of benefits:

Reimbursement to Medicaid

Insurers must repay the full amount of benefits paid by the Medicaid program within 30 days after receipt of notice.

Claims Rejected Due to Claimant Errors

An insurer that rejects a claim or pays only a portion of a claim due to an alleged error in the claim must include with the rejection or partial payment an itemized specification or explanation of benefits of the specified error. The claimant then has 15 days to submit a revised claim and may do so without waiving other legal remedies for payment. The insurer has 15 days after the resubmitted or revised claim to issue payment.

Reservation of PIP Benefits

The bill expands the requirement to reserve $5,000 of PIP benefits to physicians or dentists providing emergency treatment to include hospitals.

Log of PIP Benefits Provided

The bill requires insurers to maintain a log of PIP benefits paid by the insurer to each insured. The insurer must provide a copy of the payment log within 30 days after receiving a request for the log from the insured or an assignee.

Medical Fee Schedule [s. 627.736(5)(a), F.S.]

The bill enacts the following changes to the PIP medical fee schedule:

Ambulatory Surgical Centers and Clinical Laboratories

The bill specifies that the Medicare Part B fee schedule applies to services, supplies and care provided ambulatory surgical centers and clinical laboratories under the PIP fee schedule.

Durable Medical Equipment

The bill specifies that durable medical equipment is reimbursed at 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B.

Annual Update

The bill specifies that the Medicare fee schedule in effect on January 1 will apply to all medical care and supplies rendered in that calendar year. The annual update remains subject to the prohibition against reducing reimbursement rates below those contained in the 2007 Medicare Part B schedule.

Medicare Coding Policies and Payment Methodologies

The bill authorizes insurers to use Medicare coding policies and payment methodologies so long as they do not constitute utilization limits.

Notice of Fee Schedule

Effective July 1, 2012, an insurer may only limit reimbursement pursuant to the PIP fee schedule if the insurer provides notice at the issuance or renewal of the auto insurance policy that the insurer will provide reimbursement pursuant to the fee schedule.

Patient Disclosure [s. 627.736(5)(e), F.S.]

At the initial treatment of an insured, each medical provider must require each injured person to execute a disclosure and acknowledgment form at the initiation of treatment. The executed disclosure attests that the medical services were actually performed. Current law exempts from this requirement services billed by a provider for emergency services, emergency services and care rendered in a hospital emergency department, or for transport and treatment rendered by a licensed ambulance provider. The bill deletes the exemption for "services billed by a provider for emergency services" from the requirement that providers must execute the disclosure and acknowledgement form.

Clinic Licensure Required to Receive PIP Reimbursement [s. 627.736(5)(h), F.S.]

The bill requires all entities providing health care services to be licensed clinics in order to receive PIP reimbursement. The bill provides exemptions for a licensed hospital, licensed ambulatory surgical center, or entities wholly owned by hospitals, licensed physicians (ch. 458, F.S. and ch. 459, F.S.), licensed dentists, or licensed chiropractors or jointly owned by such practitioners and specified family members.

Notice that PIP Benefits are Exhausted [s. 627.736(6), F.S.]

If there is a dispute between an insurer and an insured or assignee and policy limits are reached, the insurer must notify the insured or assignee that policy limits have been reached within 15 days of the exhaustion of benefits.

Offer of Judgment Statute Applied to No-Fault Disputes [s. 627.736(8), F.S.]

Applies the offer of judgment statute in s. 768.79, F.S., to PIP disputes. The offer of judgment statute allows a defendant to recover attorney's fees and costs from the plaintiff if the defendant makes an offer to the plaintiff and the plaintiff's ultimate recovery is either $0 or 25 percent less than the defendant's offer. Plaintiffs may make a similar demand for judgment that requires the defendant to pay reasonable fees and costs if the plaintiff recovers a judgment that is 25 percent or more than the amount demanded. However, s. 627.428, F.S., already requires an insurer defendant to pay reasonable costs to a plaintiff upon a judgment or confession of judgment in favor of the plaintiff.

Demand Letter Requirements [s. 627.736(10), F.S.]

Limited Exemption

The bill exempts from the requirement to provide an insurer with a demand letter prior to litigating a PIP dispute:

- Hospitals;
- Insureds claiming lost wages; and
- Physicians, osteopathic physicians, and dentists who provide emergency services and care or hospital inpatient care.

Deficiency of Demand Letters

The bill specifies a demand letter is not deficient for containing calculation errors or not taking payments into account, and directs courts to evaluate a demand letter's compliance with statutory requirements using the standard of substantial compliance. If a demand letter is found deficient after a lawsuit has commenced, the insured or assignee may abate the lawsuit and correct the deficiency. The insurer must specify in its response to the demand letter each deficiency the insurer is claiming or it waives any deficiencies found in the notice.

Electronic Records [s. 627.736(16), F.S.]

Section 8 deletes the requirement that electronic transmission of records may only occur if all parties expressly agree, effective December 1, 2012. The bill allows electronic transmission of all notices, documents, communications, and transmissions required or authorized under the No-Fault law.

Office of Insurance Regulation Data Call

Section 11 requires the OIR to perform a comprehensive PIP data call and publish the results by January 1, 2015. The data call is intended to evaluate market conditions relating to the No-Fault law and measure the effects of this act.

Severability Clause

Section 12 provides that, if any provision of the act is held invalid, the provisions of the act are severable.

Effective Date

Section 13 provides that the act is effective July 1, 2012, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill is intended to reduce No-Fault motor vehicle insurance premiums by removing cost drivers related to certain medical treatments and fraud. Proponents of the bill assert that eliminating reimbursement for massage and acupuncture will reduce losses incurred by insurers and result in corresponding lower premiums for consumers. Providers who bill for massage and acupuncture within the PIP system will experience a negative economic impact.

Health care providers required to obtain clinic licensure to receive PIP reimbursement will be subject to additional costs. Entities obtaining clinic licensure or renewing clinic licensure must pay a $2,000 licensure fee. The Agency for Health Care Administration estimates that new applicants will incur approximately $5,000 in expenses associated

with preparing the licensure application, an estimate that is inclusive of the licensure fee. Proponents of this requirement assert that it will help reduce PIP fraud.

The clarifications to the PIP fee schedule are designed to reduce litigation that arises due to disputes over the proper fee amount to be paid under the schedule. Proponents of allowing insurers to use Medicare coding policies and methodologies assert that their use will result in additional savings. Representatives of some medical providers and plaintiff's attorneys have argued that allowing the use of these coding policies and methodologies incorporates utilization limits into the fee schedule. However, the bill expressly prohibits their use if they constitute a utilization limit.

C. Government Sector Impact:

Representatives from the OIR indicate that the legislation will present a significant resource challenge as the OIR expects significant numbers of auto policy contract changes to be filed to comply with various provisions of the bill. The OIR also anticipates committing significant staff resources to conduct the data call required by the bill.

Representatives from the Division of Insurance Fraud and the Agency for Health Care Administration contend that requiring medical providers to obtain clinic licensure (with exceptions) will increase the ability of agency and division personnel to discover and track clinics engaging in insurance fraud.

The Department of Financial Services also contends that the creation of a direct support organization dedicated to motor vehicle insurance fraud will increase the resources of the Division of Insurance Fraud and other law enforcement agencies to prevent, investigate, and prosecute such fraud. The direct support organization is authorized to use the monies it raises to fund insurance fraud investigators, prosecutors, and support personnel. Proponents of this provision assert this will increase the number of successful prosecutions for motor vehicle insurance fraud in the state. Concerns have been raised that using private funds to fund these provisions may create conflicts of interest in criminal prosecutions; however, the bill expressly prohibits grants and expenditures that interfere with prosecutorial independence or create conflicts of interest that threaten the success of prosecutions.

The Agency for Health Care Administration (AHCA) estimates that 250 health care providers will obtain health care clinic licensure in Fiscal Year 2012-2013 to comply with the requirement that health care providers (with exceptions) obtain clinic licensure in order to receive PIP reimbursement. An estimated 50 new licenses are anticipated for Fiscal Year 2013-2014, while in Fiscal Year 2014-2015 an estimated 250 new licenses and license renewals will be attributable to the bill. A $2,000 fee is charged to entities obtaining a new or renewal clinic license. AHCA estimates two additional staff will be required (a field surveyor and a licensure analyst) to license the additional clinics. Overall, AHCA anticipates a net gain to the Health Care Trust Fund of $374,481 in Fiscal Year 2012-2013, a loss of $18,223 in Fiscal Year 2013-2014, and a gain of $381,777 in Fiscal Year 2014-2015.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Budget on February 29, 2012:
The CS changes the bill in the following ways:

- Requires all crash reports and the drivers exchange of information form to indentify all vehicles and their passengers involved in a crash.
- The CS deletes amendatory language requiring that a long form crash report be completed in every crash involving passengers other than a driver or that involve a complaint of pain or discomfort by a party involved in the crash. It also deletes a proposed prohibition against including telephone numbers in crash reports.
- Exempts hospitals; insureds claiming lost wages; and physicians, osteopathic physicians, dentists who provide emergency services and care or hospital inpatient care from the requirement to provide an insurer with a demand letter prior to litigating a PIP dispute.
- The bill specifies a demand letter is not deficient for containing calculation errors or not taking payments into account, and directs courts to evaluate a demand letter's compliance with statutory requirements using the standard of substantial compliance. If a demand letter is found deficient after a lawsuit has commenced, the insured or assignee may abate the lawsuit and correct the deficiency. The insurer must specify in its response to the demand letter each deficiency the insurer is claiming or it waives any deficiencies found in the notice.
- Specifies that an insurer has 15 days after the resubmitted or revised claim to issue payment.

CS by Banking and Insurance on February 2, 2012:
Deletes from the bill a provision that would have prohibited insurance companies from including within their rates amounts paid to prevailing plaintiffs for attorney fees and costs.

B. Amendments:

None.