SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: March 31, 1998 Revised: _____ _____ _____ _____

Subject: Insurance (Motor Vehicle)

	Analyst	Staff Director	Reference	Action
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.				
3.				
4.				
5.				

I. Summary:

In general, every owner or registrant of a four-wheeled motor vehicle is required to maintain $10,000 of personal injury protection (PIP) insurance, also known as no-fault insurance. Subject to copayments and other restrictions, PIP insurance provides compensation for injuries to the insured driver and passengers regardless of who is at fault in an accident.

Committee Substitute for Senate Bill 2052 would revise the PIP law to:

- Allow an insurance agent to charge an applicant a fee to cover the agent's actual costs of obtaining motor vehicle records, to the extent that those costs are not otherwise compensated.
- Mandate providers submit medical bills directly to the insurer within 30 days of service. Alternatively, if the provider furnishes the insurer with 21 days notice of initiation of treatment, the provider may submit medical bills within 60 days of the service date. Neither the insurer nor the injured person is required to pay medical bills untimely submitted.
- Specify a method to determine who is the "prevailing party" entitled to attorneys fees and costs when a dispute between an insurer and a medical provider is arbitrated. Requires that the amount of the offer or claim at arbitration is the amount of the last written offer made more than 30 days before arbitration. Issues to be considered are to be submitted up to 30 days prior to arbitration.
- Provide that all statements and bills for medical services are to be submitted to the insurer on specified forms with specified procedural codes.
- Extend the time period within which the payment is due for a claim for personal injury protection insurance benefits under circumstances when an insurer makes a discovery request to a provider.

- Provide that an insurer's independent medical examination may be conducted within the municipality where the injured person is being treated, within the municipality where the injured person resides, or within 10 miles of the injured person's home, provided the location is within the insured's county of residence.

This bill amends sections 627.7295 and 627.736 of the Florida Statutes.

II. Present Situation:

Under the Florida Motor Vehicle No-Fault law (ss. 627.730-627.7405, F.S.) four-wheeled motor vehicle owners are required to maintain $10,000 of personal injury protection (PIP) insurance and, pursuant to s. 324.022, F.S., $10,000 in property damage liability insurance. PIP covers the vehicle owner, relatives residing in the same household, passengers who do not have their own PIP coverage, and persons driving the vehicle with the owner's permission. With respect to injuries sustained in a motor vehicle accident, regardless of who is at fault, a vehicle owner's PIP coverage will generally pay 80 percent of medical costs and 60 percent of lost wages and similar costs, up to a limit of $10,000. Property damage liability pays for property (vehicle) damage to others when the insured driver is at fault.

Premiums charged for PIP coverage vary by company, location, and driving record. According to premium comparisons provided by the Department of Insurance, a vehicle owner with a clean record and no youthful drivers in the household could expect to pay an annual PIP premium of $115 to $363 in Miami, $81 to $275 in Orlando, and $54 to $166 in Tallahassee. If the owner had one at-fault accident and two moving violations within the preceding 18 months, the owner could expect to pay PIP premiums of $195 to $430 in Miami, $142 to $348 in Orlando, and $99 to $180 in Tallahassee. Other motor vehicle insurance coverages, such as bodily injury liability and collision, are generally much more expensive than PIP coverage.

In general, the unfair insurance trade practices law, s. 626.9541, F.S., prohibits insurance agents from collecting charges for insurance in excess of the approved premium. Currently, subsection 627.7295(5), F.S., provides an exception to the general prohibition with respect to a policy providing only PIP and property damage liability coverage (the minimum automobile coverage allowed by law), the agent may charge a per-policy fee of up to $10 to cover administrative costs associated with selling the policy if the fee is included in the insurer's rate filing.

Motor vehicle records (MVRs) are used by some agents in determining the appropriate insurer for a particular applicant for insurance and in calculating the appropriate premium. Since MVRs contain proprietary information, the MVR cannot be obtained directly from the Department of Highway Safety and Motor Vehicles, but must be obtained from private companies who offer this service (s. 119.07, F.S.). The cost of obtaining a MVR varies between $3.10 and $4.00, depending on the method used to access the data. An insurance agent who obtains a motor vehicle report will absorb the cost of the motor vehicle report in certain circumstances, such as when the insurer does not compensate the agent for the report or when the transaction does not result in the sale of a policy.

Under subsection 627.736(4), F.S., an insurer must pay PIP benefits within 30 days after receiving notice of the claim and the amount of the loss. When a dispute arises between an insurer and a provider of medical services as to the appropriate charge, the dispute is subject to binding arbitration, with the prevailing party (as determined by the arbitrator, or, if challenged, by a court) being entitled to attorney's fees and costs. However, the provision (s. 627.736(5), F.S.) requiring an arbitration clause in all PIP policies does *not* specify what constitutes a "prevailing party." When the result of arbitration is an award higher than the amount offered by the insurer, but lower than the amount claimed by the provider, either party could be viewed as the "prevailing" party. Staff research located no reported cases construing the term "prevailing party" in the context of PIP arbitration.

A PIP insurer may refuse to pay for treatment when the treatment is not reasonable, not related to the covered motor vehicle accident, or not necessary (s. 627.736(7), F.S.). Such a determination is generally based on a medical examination conducted by a physician selected by the insurer, known as an independent medical examination (IME). In order for an insurer to exercise its right to require an IME, the insurer must be aware of the fact that treatment is being provided. The insurer has the authority to require that it be given written notice "as soon as practicable" after an accident, but there is no statutory authorization for a PIP policy to require notice of treatment and PIP policies generally do not include such a requirement. The lack of a notice requirement means that an insured could receive a lengthy series of treatments and be fully recovered before the insurer becomes aware of the treatment. Such a situation impairs the insurers ability to determine whether the treatment was reasonable, related, or necessary, and would be required to pay the claim.

The IME must be conducted within the municipality in which the injured party resides or within the municipality in which the injured party is receiving treatment (s. 627.736(7), F.S.). When there is no qualified physician within the municipality of the injured party's residence, the IME must be conducted "in an area of the closest proximity" to the residence. With respect to an injured party who resides in a small municipality that has few practicing physicians, the requirement of an IME within the municipality restricts the choice of physicians to conduct the IME. If there are no qualified physicians in the municipality, the ambiguous term "area of closest proximity" could be interpreted either to give insurers broad discretion or to require insurers to select the one physician who is geographically closest to the injured party's home.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.7295, F.S., to allow general lines agents to charge an applicant for motor vehicle insurance a reasonable, non-refundable fee to obtain a motor vehicle report (MVR) to reimburse the agent the actual cost of obtaining the report. This provision would apply to the extent an agents cost of obtaining MVRs on applicants for motor vehicle insurance is not otherwise compensated. The amount of the fee could not exceed the agents *actual costs* in obtaining the report that are not otherwise compensated. That is, if the agent's out-of pocket cost of obtaining the MVR was not included in the insurers rate filing or otherwise included in the commission paid to the agent, the agent could recoup the actual cost from the applicant. *Actual*

cost is defined as the cost of obtaining the report on an individual driver basis or the pro rata cost per driver when the report is obtained on more than one driver. Additionally, in no case may the actual cost include subscription or access fees associated with obtaining MVRs via on-line computer.

Section 2. Amends s. 627.736, F.S., relating to the personal injury protection insurance law to provide that except in the case of hospital services provided within the first 30 days after the motor vehicle accident and except for past due amounts previously billed on a timely basis, the statement of charges presented to the insurer by the provider could not include, and the insurer would not be required to pay, charges for treatment or services rendered more than 30 days before the postmark date of the statement. However, if the provider submits to the insurer a notice of the initiation of treatment within 21 days of its first examination or treatment of the claimant, then the statement may include charges for treatment or services rendered up to, but not more than, 60 days before the postmark date of the statement.

The injured party would not be liable for, and the provider could not bill the injured party for, any charges that were unpaid as a result of the failure of the provider to comply with the billing requirements. Additionally, any agreement requiring the injured person or insured to pay for such charges would be unenforceable. A specified notice of the billing requirements would be outlined on the notice of insured's rights which the insurer is required to provide after notice of an accident. The result of both the 30-day and 60-day billing requirements, is that insurers would be aware of the commencement of treatment and would be in a better position to assure that treatment is reasonable, related to the motor vehicle accident, or necessary. Additionally, these provisions would reduce the practice of *bulk billing* by some providers which occurs when treatments are rendered over a period of time and the insurer is subsequently billed for multiple treatments.

The bill would clarify which party is the "prevailing party" and therefore entitled to an award of attorney's fees and costs when a dispute between an insurer and a medical provider is arbitrated. When the award to the claimant (provider) consists of the amount offered by the insurer at arbitration plus *more than 50 percent* of the difference between the offer and the amount claimed at arbitration, the claimant would be the prevailing party. When the award consists of the amount offered by the insurer at arbitration plus *less than 50 percent* of the difference between the offer and the amount claimed at arbitration, the insurer would be the prevailing party. Furthermore, when the award consists of the amount offered by the insurer at arbitration plus 50 percent of the difference between the offer and the amount claimed at arbitration, there would be no prevailing party. To the extent that a claimant may currently be considered the "prevailing" party in any case in which the arbitration award exceeds the amount offered by the insurer, this change could be expected to reduce the number of situations in which insurers are required to pay the attorney's fees and costs of medical services providers.

The bill provides a deadline as to arbitration issues and the amount of the offer or claim to be presented at arbitration. Specifically, the amount of the offer or claim at arbitration is the amount of the *last* written offer or claim made more than 30 days before the arbitration. Each party must

identify individual issues relating to examination or treatment which are in dispute up to 30 days prior to arbitration and each party is precluded from adding additional issues after that deadline. The effect of these provisions is that each party would have the benefit of knowing in advance each issue which would be determined at arbitration. Furthermore, these provisions would appear to encourage fairer, more expedited resolution of disputes.

Under this bill, all statements and charges for medical services rendered by medical providers must be submitted to the insurer on standard forms approved by the Department of Insurance, i.e., HCFA (Health Care Financing Administration) 1500 forms, UB 92 forms. Furthermore, such statements, to the extent applicable, must contain appropriate physicians' current procedural terminology (CPT) in the year in which the services are rendered. Also, medical services requiring licenses must be performed by validly licensed persons. Lastly, the insurer shall not be considered to have been furnished with proper notice of the amount of covered loss of medical bills due unless such statements comply with the provisions outlined above. These provisions attempt to standardize billing statements and would have the effect of reducing any ambiguity as to which medical treatments were provided. These provisions would make it easier for insurers to understand precisely what medical services they are compensating.

The bill sets forth certain time limits as to the discovery provisions under the PIP law. If the insurer makes a written request for documents within 20 days of receiving notice of the amount of covered loss under s. 627.736(4)(a), F.S., the insurer's obligation to pay must be in accordance with s. 627.736(4)(b), F.S., which is 30 days after notice of covered loss and amount of such loss, or within 10 days after the insurer's receipt of the requested documentation, whichever occurs *later*. The term *receipt* includes inspection and copying of documents. Should the provider fail to timely provide medical records to the insurer, the insurer's 30-day payment requirement would be tolled until 10 days *after* the insurer receives the records. This provision would aid insurance companies by allowing them to review their insured's medical treatment records and ascertain whether services were performed and billed correctly.

The bill further provides that an independent medical examination (IME) could be conducted in the municipality in which the injured party is receiving treatment or in a location reasonably accessible to the injured party, defined as a location within the municipality in which the injured party resides or a location within 10 miles by road of the injured party's residence, as long as the location is within the county in which the injured party resides. When there is no qualified physician within a "location reasonably accessible," the IME could, as under current law, be conducted in "an area of the closest proximity to the insured's residence." These changes would broaden an insurance company's choice of physicians to conduct the IME in situations where the number of practicing physicians in a municipality is limited.

Section 3. Provides that the bill will take effect October 1, 1998.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

See discussion below under Private Sector Impact Section.

B. Private Sector Impact:

The bill would allow agents to charge applicants for motor vehicle insurance a fee to recover their otherwise uncompensated costs of obtaining motor vehicle reports on applicants for insurance. The amount of the fee is likely to be $3-$4.

The specification as to who is the prevailing party (and therefore entitled to award of attorney's fees and costs) in arbitration of disputes between PIP insurers and medical services providers could reduce the number of instances in which fees and costs are awarded to the provider and increase the number of instances in which fees and costs are awarded to the insurer. It may also act as a "chilling effect" on a provider's decision whether to arbitrate a dispute. Instituting time limitations as to arbitration would result in more disputes being settled, thereby reducing costs.

The bill would increase a PIP insurers ability to prevent payment for treatment that was unreasonable, unrelated to a covered accident, or unnecessary, and could thereby lower the insurer's cost of providing PIP coverage. The 30 and 60 day billing requirements, the standardization of medical statements and codes, and the revision of geographic requirements for an independent medical examination (IME) of a claimant could make the IME a more effective cost-control tool. These cost savings could benefit consumers by reducing the costs upon which insurers base PIP premiums and counteracting upward pressures on PIP premiums. Providers who fail to meet the notice requirements will not be compensated for their services.

To the extent that the revision of geographic requirements for an independent medical examination (IME) increases the likelihood that an IME would be conducted by a physician preferred by the insurer, there may be an increase in denied claims. However, to the extent that this change reduces the likelihood that an IME would be conducted by a physician not preferred by the insurer, there may be a decrease in PIP claims payments for treatments that are unreasonable, unrelated to the motor vehicle accident, or unnecessary.

C. Government Sector Impact:

Government-owned vehicles (except certain mass-transit vehicles) are covered under Florida's No-Fault law's PIP insurance requirements. As a policyholder or self-insurer, governmental entities would experience the same impact as would policyholders and insurers, described above.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The term "hospital services" under s. 627.736(5)(b), F.S., is not defined in the bill or in the chapter being amended. It is not clear whether medical services performed by a physician in a hospital and billed directly by the physician to the insurer would be exempt from the provisions of the 30 and 60 day billing provisions.

The arbitration time limit provisions under s. 627.736(5), F.S., are not the same as to when the offer and demand must be made and when issues are to be identified prior to arbitration. Offers or claims must be made "more than 30 days prior to arbitration" whereas issues must be identified "up to 30 days prior to arbitration."

VIII. Amendments:

None.