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.)

BILL: CS/SB 426

SPONSOR: Banking and Insurance Committee and Senator Geller

SUBJECT: Automobile Insurance-Personal Injury Protection Insurance Claims

DATE: March 6, 2000 REVISED: _____ _____ _____ _____

	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.

Under the current PIP provision pertaining to charges for treating injured persons, providers are required to submit medical bills directly to the insurance company within 30 days of the date of service (s. 627.736, F.S.). Alternatively, if the provider furnishes the insurer with notice of the initiation of treatment within 21 days of first treatment, the provider may submit bills within 60 days of the service date. Medical bills which are not submitted within this time-frame are considered untimely and neither the insurer nor the injured person is required to make payment.

Committee Substitute for Senate Bill 426 increases the allowable time for a provider to submit medical bills to insurers from 30 to 60 days of the date of service. However, if the insured fails to furnish the provider with the correct name and address of the insured's PIP insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of charges. Further, the insurance company is not required to pay such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 60-day period demonstrating that the provider reasonably relied on erroneous information from the insured; includes either a denial letter from the incorrect insurer or proof of mailing reflecting timely mailing to the incorrect address or insurer; and provides a copy of the statement of charges to the Department of Insurance. The bill also deletes the provision allowing providers to submit bills within 60 days of the service date if they provide notice to the insurer within 21 days of first treatment.

This committee substitute amends section 627.736, Florida Statutes.

II. Present Situation:

Under the Florida Motor Vehicle No-Fault law (ss. 627.730-627.745, 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.

In 1998, the Legislature substantially amended the PIP provision dealing with billing for treatment of injured persons to require that providers submit medical bills directly to the insurer within 30 days of the date of service [s. 627.736(5), F.S., ch. 98-270, Laws of Florida]. 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. The medical bills may include past due amounts previously billed on a timely basis. Neither the insurer nor the injured person is required to pay medical bills untimely submitted and any agreement to the contrary is unenforceable. An exception is provided for medical services billed by a hospital for services rendered at a hospital-owned facility, for emergency services rendered by a hospital emergency department, or for the transport and treatment rendered by an ambulance provider. The above billing information is included in the notice of insured's rights which is provided to policyholders after notice of an accident and is in type no smaller than 12 points. The 1998 amendments also authorized medical statements and billing codes to be standardized and the geographical requirements for an independent medical examination (IME) of the claimant were revised. The legislation took effect on October 1, 1998.

According to officials with several insurance companies, the 1998 PIP legislation was necessary to prevent payment for treatment that was unreasonable, unrelated to a covered accident, or unnecessary, and would thereby lower the insurer's cost of providing PIP coverage. These provisions helped insurers to determine whether the claim was fraudulent by enabling companies to investigate the claim and possibly require an IME within a reasonable time after medical treatment. Furthermore, these provisions may benefit consumers by reducing the costs upon which insurers base PIP premiums and counteract upward pressures on PIP premiums. A representative with Nationwide Insurance Company states that the company has experienced a 29% decrease in the number of PIP lawsuits filed due to the changes enacted in 1998. Furthermore, having deadlines for submitting medical bills has helped 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 which often reach the total amount of PIP benefits.

Insurance companies assert that they are likewise under a 30-day time requirement to pay PIP benefits to providers after receiving notice of the claim, the amount of the loss, and investigating the claim. Insurers are also subject to lawsuits if they do not timely pay providers and must pay attorney's fees if they lose (s. 624.155, F.S., and s. 627.428, F.S.). Insurance companies are

further in violation of the insurance code if they fail to timely provide benefits with such frequency as to constitute a general business practice [s. 627.736(4), F.S.].

A PIP insurer may refuse to pay for treatment if the insurer has reasonable proof that the insurer is not responsible for the payment [s. 627.736(4), F.S.]. Additionally, the 30-day payment requirement may be tolled if the insurer requests medical records within 20 days of receipt of the medical bills in issue and the provider fails to timely furnish such records [s. 627.736(6), F.S.]. Upon receiving the requested records, the insurer must provide payment within 10 days. The 30-day payment mandate may also be tolled if the insurer is not furnished statements or bills for medical services which do not utilize proper medical forms and codes [s. 627.736(5), F.S.]. However, two recent court decisions by the Third District Court of Appeals [(*Perez vs. State Farm,* 1999 WL 821091 (Fla. 3rd DCA 1999) and *United Automobile Ins. Co. V. Viles,* 726 So. 2d 320 (Fla. 3rd DCA 1998)] have eroded an insurer's ability to contest certain claims. In *Perez,* the Court held that the insurance company was required to obtain, within 30 days, medical reports providing reasonable proof than it was not responsible for payment. The insurer had argued that failure to obtain the report did not compel payment of the bills, but only subjected it to paying interest and attorney's fees should liability be established. The Court countered that the insurer lost its right to even contest the claim. Similarly, in *Viles,* the Court held that an insurer could not terminate an insured's PIP benefits without a report by a physician, and thus the insurer was liable for all bills.

Representatives from several provider groups state that the current 30-day billing requirement is unduly harsh because providers who fail to meet that deadline, even through no fault of their own, will not be compensated for their services. Sometimes accident victims do not know who their insurance company is at the time of treatment, or state the incorrect insurer to the provider, e.g., name their general health care insurer rather than their automobile insurer. In either case, if the wrong insurer is billed and the 30-day time period lapses, there is no remedy for the provider to obtain compensation.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.736, F.S., relating to the personal injury protection (PIP) insurance law, to expand the time period from *30 to 60 days* for providers to submit medical bills directly to the insurance company from the date of service. However, if the insured fails to furnish the provider with the correct name and address of the insured's PIP insurer, the provider has *35 days* from the date the provider obtains the correct information to furnish the insurer with a statement of charges. Additionally, the insurance company is not required to pay such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 60-day period demonstrating that the provider reasonably relied on erroneous information from the insured; includes either a denial letter from the incorrect insurer or proof of mailing reflecting timely mailing to the incorrect address or insurer; and provides a copy of the statement of charges to the Department of Insurance.

The committee substitute removes a provision in the law which is now not necessary because of the amendment noted above. That provision stated that a provider could submit medical bills within 60 days of the service date if the provider furnished the insurer with a notice of initiation of treatment within 21 days of the first examination date.

As noted under the Present Situation Section above, proponents of this legislation argue that the 30-day requirement for submitting medical bills is unreasonable because there is no remedy if the deadline has run due to no fault of the provider. The provider is barred from being compensated. Under the committee substitute, the time period for providers to submit medical bills to the insurance company is doubled and there is a remedy if the provider is given incorrect information by the insured.

Insurance companies assert that extending the deadline to 60 days could result in bulk billing by providers which results in billing out all PIP benefits before the insurer is even notified their insured is involved in an accident. Additionally, the cost savings achieved by having providers adhere to strict deadlines may be eroded by this legislation.

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:

None.

B. Private Sector Impact:

Medical providers will benefit by having more time, e.g., 60 days from the date of service, in which to submit bills to insurance companies for services provided to PIP insureds. Additionally, if the insured fails to give the provider the correct name and address of the PIP insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of charges, so long as specified documentary evidence is provided the insurer.

The provisions which allow more time for providers to submit bills to insurance companies might hamper the ability of the companies to investigate a claim and could increase the cost of PIP claims and premiums.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.