SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Banking and Insurance Committee

BILL: CS/SB 2114

INTRODUCER: Banking and Insurance Committee and Senator Garcia

SUBJECT: Florida's Motor Vehicle No-Fault Law

DATE: March 28, 2006 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	**Fav/CS**
2.			HE	
3.			JU	
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I. Summary:

In 2003, the Legislature repealed Florida's Motor Vehicle No-Fault law[1] to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after October 1, 2006.[2] In November, 2005, the staff of the Senate Banking and Insurance Committee published, *Florida's Motor Vehicle No-Fault Law* (Interim Project Report 2006-102).[3] The Interim Report made the recommendation to reenact the no-fault law along with additional reforms to control costs, reduce litigation, combat fraud and provide resources to the Division of Insurance Fraud. The Committee Substitute for Senate Bill 2114, contains many of the recommendations made in the Interim Report to provide for the following:[4]

- Reenact Florida's No-Fault Law, but provide for future repeal on January 1, 2009;
- Eliminate the contingency risk multiplier as applied to attorney fee awards in no-fault cases;
- Combat insurance fraud by:
  - Providing that it is a second degree felony for a person to organize, plan or knowingly participate in a scheme to create documentation of a motor vehicle crash that did not occur ("paper" or "phantom" accident) and provides for a two year minimum mandatory term of imprisonment;

[1] The affected sections are: ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S. Insurers are authorized to provide, in all policies issued or renewed after October 1, 2006, that such policies may terminate on or after October 1, 2007.

[2] Ch. 2003-411, L.O.F.

[3] See Report at: http://www.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf.

[4] For the purposes of the single subject limitation, the other recommendations are contained in SB 2112 and SB 2116 (Senate Banking and Insurance Committee). Many of the insurance fraud recommendations are contained in SB 1124 (Sen. Posey) and SB 1596 (Sen. Alexander).

  - Expanding the applicability of the fraudulent motor vehicle insurance statute to provide that persons who present false or fraudulent proof of motor vehicle insurance commit a third degree felony;
  - Requiring specific information which must be in a crash report form and providing that the absence of information in a crash report, regarding the existence of passengers in the vehicle (involved in a crash), constitutes a "rebuttable presumption" that *no* such passengers were involved in the reported crash; and
  - Authorizing the Department of Highway Safety and Motor Vehicles to revoke the driver's license of persons convicted of patient brokering, solicitation or participating in a staged motor vehicle accident;
- Provide for a total appropriation of $2,622,748 to fund 19 positions within the Division of Insurance Fraud and to provide a competitive pay adjustment of $10,000, plus benefits, for each of the existing 122 sworn law enforcement positions within DIF;
- Provide for a total appropriation of $750,000 to fund 6 additional insurance fraud prosecutors in 6 circuits in Florida;
- Specify criteria for the Department of Health to determine that certain tests are medically unnecessary under no-fault;
- Require insurers to provide policyholders and their assignees, upon written request, with a report itemizing all payments made with a copy of the insurance declarations page and insurance policy within 30 days after such request;
- Increase the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days;
- Revise and clarify billing and coding requirements for providers;
- Reduce the number of days for a health care provider to submit charges to an insurer from 75 to 50 days, if the provider notifies the insurer within 21 days of first treatment;
- Require that providers of emergency services furnish a statement of charges within 75 days of the date treatment was rendered;
- Require PIP health care providers to give patients a written bill or similar document disclosing in plain language the treatment rendered and cost associated with such treatment at the time of service and to require the insured to sign the written bill or similar document and maintain a copy as part of the patient's medical records and provide exceptions for hospitals, emergency care providers and providers who do not render services in the presence of the insured;
- Clarify that a parent or legal guardian of an insured minor complete an application for PIP benefits;
- Require self-employed injured persons to produce reasonable proof to demonstrate loss of income and earning capacity to insurers;
- Clarify that if an insured elects to have disability benefits reserved for lost wages, the insured must notify the insurer in writing;
- Require that all amounts repayable to an insurer include the statutory interest penalty under s. 55.03, F.S.;
- Require that medical records of an injured person be available at the provider's principal place of business within 25 working days after a request for such records and if such records are not made available within this time period and such records are later

admitted into evidence or otherwise used to support a claim for benefits, the court shall not award attorney's fees to the provider;
- Restrict venue for a PIP lawsuit in cases where there has been as assignment of benefits to the jurisdiction where the injured party resides, where the accident occurred or where the disputed health care services were performed; and,
- Reorganize the statutory provisions of the personal injury protection (PIP) benefits section (s. 627.736, F.S.) for the purpose of clarifying its meaning and intent and for the purpose of better comprehension.

This bill substantially amends the following sections of the Florida Statutes: 627.736, 316.068, 322.26, 817.234, and 817.2361.

II. Present Situation:

Florida's Motor Vehicle No-Fault Insurance Law (Current Provisions, Mandatory and Optional Coverages, Tort Threshold, Financial Responsibility)
In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan. The no-fault reform was offered as a viable replacement for the tort system as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault.

Under current law, motorists are required to purchase personal injury protection (PIP) and property damage (PD) liability coverages.[5] The no-fault coverage, referred to as PIP, provides $10,000 of coverage for the following: payment of 80 percent of reasonable medical expenses, 60 percent of loss of income, plus a $5,000 death benefit, for bodily injury sustained in a motor vehicle accident, without regard to fault. Personal injury protection covers the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the insured motor vehicle. This coverage also 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 the vehicle accident, except in the following cases:
(1) significant and permanent loss of an important bodily function;
(2) permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement;
(3) significant and permanent scarring or disfigurement; or
(4) death.

This is known as the "verbal threshold" which means that suits for pain and suffering may commence only if injuries meet these levels of seriousness.

Current law also requires vehicle owners to obtain $10,000 in property damage (PD) liability coverage which pays for the physical damage expenses caused by the insured to third parties in

[5] Sections 627-730-627.7405, F.S.

the accident. Additionally, under Florida's Financial Responsibility law, motorists must provide proof of ability to pay monetary damages for bodily injury liability (BI) and PD liability after motor vehicle accidents or serious traffic violations. The minimum amounts of liability coverage are $10,000 in the event of injury to one person, $20,000 for injury to two or more persons, and $10,000 property damage, or $30,000 combined single limits. Many drivers purchase "optional" coverages in addition to mandatory insurance including bodily injury liability, (which may be required by the Financial Responsibility Law), uninsured motorist, collision, comprehensive, medical payments, towing, rental reimbursement and accidental death and dismemberment. Insurers may not require motorists to purchase any of these optional coverages.

The Legislature enacted significant no-fault reforms in 2001 and 2003;[6] however, according to many stakeholders, these reforms have not gone far enough in resolving the problems within the no-fault system which include fraud, abuse, inappropriate medical treatment, inflated claims, inadequate compensation to victims, increased premiums, and the proliferation of law suits. As a result of these concerns, in 2003 the Legislature repealed the Motor Vehicle No-Fault law to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after October 1, 2006.

Committee Staff Report and Recommendations

In November, 2005, the staff of the Senate Banking and Insurance Committee published, *Florida's Motor Vehicle No-Fault Law* (Interim Project Report 2006-102). The report found that Florida has a costly automobile insurance system with serious problems, though not at a "crisis" level. The market is competitive and coverage is readily available. Florida experienced significant premium increases, particularly for PIP coverage, from 1999 through 2003. But, this has been followed by rate decreases or very small increases in 2004 and 2005. PIP loss costs in Florida have also leveled off, but they have continued to outpace other no-fault states for at least the last five years. Loss costs for BI liability insurance in Florida are also well above the national average and higher than most no-fault states. High medical costs and utilization of medical services continue to drive PIP costs and the incidents of PIP fraud and abuse, primarily involving health care fraud, are at an all time high. Anti-fraud measures have helped to increase the number of arrests and prosecutions, but the resources of the Division of Insurance Fraud are limited.

The no-fault law meets the goal of compensating victims (and their medical providers) much more timely than under a traditional tort system. But, the efficiencies expected from no-fault due to decreased litigation and expense related to proving fault have not been fully realized due to the expenses associated with investigating and litigating the cost and utilization of medical services. However, reforms enacted in Florida in 2003 appear to have been effective in reducing such litigation. The report made the recommendation to reenact the no fault law along with other recommendations to control costs, reduce litigation, combat fraud, provide stronger regulation for health care clinics and provide resources to the Division of Insurance Fraud.

[6] Chapters 2001-271, L.O.F., 2001-163, L.O.F., and 2003-411, L.O.F.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.736, F.S., which applies to PIP benefits, to reorganize the section for the purpose of clarifying its meaning and intent, and for the purpose of better comprehension. Under subsection (1), the bill requires an injured person who is self-employed or an injured person who owns over a 25 percent interest in his or her employer to produce to the insurer reasonable proof of income and loss of earning capacity, as a condition precedent to payment. The bill clarifies current law to provide that every employer shall, if a request is made by an insurer, furnish a sworn statement of earnings since the time of injury and "for a 13-week period" before the injury, of the person upon whose injury the claim is based.

Also, the bill clarifies that if an insured elects to have disability benefits reserved for lost wages, the insured must notify the insurer in writing, which shall be binding on the insurer. Receipt of this notification will take priority over all claims subject to an assignment of benefits received after receipt of such notice. An exception is provided that if a properly perfected hospital lien is received by the insurer prior to the payment of the lost wage claim, the hospital lien will take priority over the insured's election to reserve benefits for lost wages. Finally, the bill inserts within subsection (1) the current law provision pertaining to Medicaid benefits.

In subsection (5), the bill provides criteria for the current authority for the Department of Health (DOH) to adopt rules determining whether a test is medically necessary as currently defined in s. 627.732, F.S., for use in either the diagnosis or treatment of persons injured under PIP. The DOH may consider the degree of positive diagnostic or treatment benefits in relation to costs; whether there is substantial demonstrated medical value for the injured person; the availability of alternative methods of treatment or diagnosis; the immediacy or remoteness of likely benefit for the injurer person; whether there is evidence of overuse of the test by providers for financial gain; whether there is acceptance of use of the tests; and whether there are reservations regarding the test as reported by the appropriate professional licensing boards. The DOH is directed to give greater weight to the advice of the licensing boards than to a degree of acceptance by individuals within the relevant provider community.

Under subsection (6), the bill inserts current law pertaining to required payment of benefits by insurers. In subsection (7), the legislation states that a parent or legal guardian of an insured minor must, upon request of the insurer, complete an application for PIP benefits.

The bill transfers current law to subsection (7) regarding charges for treatment of injured persons and revises and clarifies the billing and coding requirements for PIP benefits to reflect current practices. Health information coding is the transformation of verbal descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations. Currently, reimbursement of hospital and physician claims for Medicare patients depends entirely on the assignment of codes to describe diagnoses, services, and procedures provided.[7] The bill requires all billings for services to comply with the Health Care Procedure Coding System (HCPCS). The (Physicians' Current Procedural Terminology (CPT)) coding system is deleted because HCPCS is a broader term that includes both the CPT coding system and the national coding system.[8] The current

[7] See American Health Information Management Association site: http://www.ahima.org/.

[8] The national coding system describes services and supplies not found in the CPT codes such as durable medical equipment, ambulance services, medical/surgical supplies, drugs, orthotics/prosthetics, dental procedures and vision services.

statutory reference to ICD-9 is removed and the correct, updated term is inserted: the International Classification of Diseases (ICD-9-CM). The "CM" refers to clinical modification and it is updated annually through a review process in order to make codes more precise due to new discoveries and medical advancements.

The bill clarifies that claim forms submitted by providers include the "signature" and the "date" of the signature. The bill also clarifies that a statement of medical services may not include charges for services of a person that performed such services without possessing all valid "qualifications" and licenses "required to lawfully provide such services." The bill inserts current law language pertaining to charges for specified medically necessary tests including magnetic resonance imaging services under subsection (7).

Under the direct billing for PIP benefits provision, the bill clarifies that the insurer may pay for charges directly to the "insured or the insured's assignee." The insured receiving treatment (or his or her guardian) must countersign the properly completed CMS 1500 form or its successor or UB 92 form or its successor submitted for payment, although exceptions are provided for hospital and emergency services and care rendered under s. 395.002, F.S., and for health care providers who do not render services in the presence of the insured.

Under subsection (7) (timely billing for non-emergency services), the number of days for a health care provider to submit charges to an insurer is reduced from 75 to 50 days, subject to the provider notifying the insurer within 21 days of first treatment. For emergency services provided under PIP, the legislation requires that such providers furnish a statement of charges within 75 days of the date treatment was rendered. Currently, there is no time limitation on submission of charges for emergency services. The bill inserts current law language providing that the insured person is not liable for, and the provider may not bill the insured for charges that are unpaid because of the emergency provider's failure to comply with the emergency services provisions and any agreement requiring such is unenforceable.

Under the billing notice and disclosure provisions (subsection (7)), a health care provider is required to give patients a written bill or similar document disclosing in plain language the treatment rendered and cost associated with such treatment on each date services are rendered. The insured must sign the written bill and the provider must maintain a copy of the bill or document as part of the patient's medical records. Exceptions are provided for hospital and emergency services and for providers who do not render services in the presence of the insured.

Insurers are mandated to provide policyholders and their assignees, upon written request, with a report itemizing all payments made with a copy of the insurance declarations page and a copy of the insurance policy within 30 days after the written request. The bill inserts current law language providing that benefits are not due or payable on behalf of an insured if that person has committed PIP insurance fraud under specified circumstances.

The bill clarifies current law providing that PIP benefits paid will be overdue if not paid within 30 days after the insurer is furnished with "properly completed CMS 1500 form or its successor or UB 92 form or its successor, assignment of benefits, or, in the case of disability benefits,

written documentation of the claim." Under subsection (10), all amounts repayable to an insurer must include the statutory interest penalty under s. 55.03, F.S.[9]

Under the demand letter provisions of subsection (12), the bill increases the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days. Subsection (14) requires that medical records of an injured person be available at the provider's principal place of business within 25 working days after a request for such records and if such records are not made available within this time period, and such records are later admitted into evidence or otherwise used to support a claim for benefits, the court shall not award attorney's fees to the provider under this provision or under s. 627.428, F.S. (attorney fees provision). Subsection (17) pertains to attorney's fees under the state's no-fault law and eliminates the contingency risk multiplier as applied to attorney fee awards. Subsection (19) retains the current law language regarding civil actions for insurance fraud and subsection (21) retains the current law provision as to rewards for persons pertaining to improper billing by providers.

Subsection (22) of the bill restricts venue as to PIP lawsuits in the case of an assignment of benefits to the jurisdiction where the injured party resides, where the accident occurred or where the disputed health care services were performed.

Section 2. Amends s. 316.068, F.S., relating to crash report forms. The bill specifies information which must be in a crash report form including time, date and location of crash, number and identify of passengers in vehicle and names and addresses of all witnesses, parties and drivers. The legislation states that the absence of information in a crash report regarding the existence of passengers in the vehicles involved in a crash constitutes a "rebuttable presumption" that no such passengers were involved in the reported crash.

Section 3. Amends s. 322.26, F.S., pertaining to the mandatory revocation of a driver's license by the Dept. of Highway Safety and Motor Vehicles (DHSMV) based upon conviction of specified offenses. The bill adds convictions for patient brokering under s. 817.505, F.S.; solicitation under s. 817.234(8), F.S.; or participating in a staged motor vehicle accident under s. 817.234(9), F.S., to the list of such offenses.

Section 4. Amends s. 817.234, F.S., pertaining to the false and fraudulent insurance claims law. The bill makes it a second-degree felony (with a two-year minimum mandatory term of imprisonment) to plan or organize a "scheme to create documentation of a motor vehicle crash that did not occur" for purposes of a tort claim or for PIP benefits. This penalty currently applies to "staged accidents." According to representatives with DFS, criminalizing the activities of intentionally causing a "paper accident" would help deter motor vehicle insurance fraud.

The bill clarifies that any "service" provider (except a hospital) who waives deductibles or copayments as a general business practice commits insurance fraud. The proposal also deletes the term "patient" and inserts the term "insured" to designate the person for whom, or entity for which, a service provider would agree to waive deductibles or copayments.

[9] Under s. 55.03, F.S., the Chief Financial Officer establishes the rate of interest on December 1 of each year to take effect January 1st of the following year.

Section 5. Amends s. 817.2361, F.S., relating to false or fraudulent motor vehicle insurance. Current law makes it a third-degree felony to create, market, or present a false or fraudulent "insurance card." The bill deletes the term "card" and expands the applicability of the statute to provide that any person who presents false or fraudulent "proof of" motor vehicle insurance commits a third-degree felony.

Section 6. Provides that for the 2006-2007 fiscal year, a total appropriation of $2,622,748 to fund 19 positions within the Division of Insurance Fraud and to provide a competitive pay adjustment of $10,000, plus benefits, for each of the existing 122 sworn law enforcement positions within DIF from the Insurance Regulatory Trust Fund. This appropriation is for the purposes provided in s. 626.989, FS., and as follows:

- $1,533,296 is appropriated on a recurring basis to provide a salary increase of approximately $10,000 for each of the 122 existing sworn law enforcement officers in the division, in order to achieve relative parity with sworn law enforcement investigators who have similar responsibilities at other state law enforcement agencies;
- $621,731 to fund nine positions in new fraud unit within the division, consisting of six sworn law enforcement officers, one non-sworn investigator, one crime analyst, and one clerical position; and,
- $467,721 to fund ten non-sworn analysts/investigators.

Section 7. Provides that for the 2006-2007 fiscal year, the sum of $750,000 in recurring funds is appropriated from the Insurance Regulatory Trust Fund to the State Attorneys for the 4th (Duval), 6th (Pinellas), 9th (Orange), 13th (Hillsborough), 15th (Palm Beach) and 17th (Broward) circuits to establish and fund an additional assistant state attorney position in each such circuit for the purpose of prosecuting cases of insurance fraud.

Section 8. Provides that effective January 1, 2009, specified sections of the Motor Vehicle No-Fault Law are repealed, unless reviewed and reenacted by the Legislature prior to that date.

Section 9. Repeals s. 19 of chapter 2003-411, Laws of Florida. This deletes the law that repeals the Florida Motor Vehicle No-Fault Law, effective October 1, 2007.

Section 10. Provides that the act shall take effect October 1, 2006.

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:

Insureds should benefit under the provisions of the bill in that they will be given written bills disclosing in plain language the treatment they have received and the costs incurred for such treatment.

Persons would be subject to specified penalties, including criminal prosecution, for various fraudulent insurance acts specified by the bill.

Plaintiff attorneys will likely be impacted by the elimination of the contingency risk multiplier which is customarily applied in PIP cases in many jurisdictions should the plaintiff prevail over the insurer. Elimination of the multiplier should help to reduce PIP loss costs and PIP premiums.

C. Government Sector Impact:

The bill appropriates $2,622,748 from the Insurance Regulatory Trust Fund to fund nineteen DIF positions and to increase salaries by $10,000 for the 122 existing law enforcement positions within DIF. The sum of $750,000 is appropriated from the Trust Fund to provide for six prosecutors in the designated circuits. These amounts are prorated for the 2006-07 fiscal year to conform to the October 1 effective date of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

There are two other bills related to the Banking and Insurance Committee interim project report, *Florida's Motor Vehicle No-Fault Law* (Interim Report 2006-102): SB 2116 (public records, motor vehicle crash reports) and SB 2112 (health care clinics).

VIII. Summary of Amendments:

None.