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: SPB 7094

SPONSOR: For consideration by Banking and Insurance Committee

SUBJECT: Florida Motor Vehicle No-Fault Law

DATE: February 13, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh		**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

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In 2003, the Legislature repealed Florida's Motor Vehicle No-Fault law[1] to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session and such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, provided that additional reforms are enacted to control costs, most importantly, a medical fee schedule. Senate Proposed Bill 7094 contains the majority of the recommendations made in the Interim Report to provide for the following:[4]

- Reenact Florida's No-Fault Law;
- 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;
- Adopt a medical fee schedule for all personal injury protection insurance benefits to be set at an unspecified percentage of the Medicare fee schedule. Treatments and charges not compensable under Medicare are not compensable by the insurer. The bill eliminates all other fee schedules currently under PIP.

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[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 SPB 7108 and SPB 7110 (Senate Banking and Insurance Committee). Many of the Insurance fraud recommendations are contained in SB 1124 (Sen. Posey) and SB 1596 (Sen. Alexander).

- Eliminate the contingency risk multiplier as applied to attorney fee awards in no-fault cases;
- Allow an insurer to bring a civil cause of action to recover amounts paid and expenses incurred against a person presenting a PIP claim if the court determines the person knew or should have known that the claim meets specified fraudulent or other unlawful criteria;
- Remove the requirement that a person be convicted, or plead guilty or nolo contendere for insurance fraud or other crimes in order for a PIP insurer to pursue a civil action;
- 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;
- 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 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;
- 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;
- Clarify that a parent or legal guardian of an insured minor complete an application for PIP benefits;
- Clarify the requirements for a valid assignment of benefits and for priority of payment;
- Require that all amounts repayable to an insurer include the statutory interest penalty under s. 55.03, F.S.;
- Increase the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days;
- Require that medical records of an injured person be available at the provider's principal place of business within 5 working days after a request for such records and such records are deemed nonexistent if not timely provided.
- Clarify which persons are subject to an examination under oath, specify the hourly rate ($175) to be paid by the insurer, and provide for other provisions;
- Require insureds to attend independent medical examinations (IMEs) and mandate insurers pay insureds for lost wages for time missed from work. Providing for other requirements;
- Require that notice to an insurer of the existence of a claim must be reported within 1 year of the occurrence and allow for insurers to contract for such notice to be less than 1 year;
- Remove the monetary limit on a reward that may be provided to persons notifying insurers of improper billing;

- Restrict venue for a PIP lawsuit to the jurisdiction where the injured party resides or where the accident occurred. If an assignment of benefits has been made, venue would be where the health care services were performed; and,
- Clarify that the provisions under s. 627.736, F.S., (personal injury protection benefits) do not preempt or supersede any cause of action that may otherwise be available.

This bill substantially amends sections 627.732 and 627.736 of the Florida Statutes.

II. Present Situation:

Florida Motor Vehicle No-Fault Insurance Law (Current Provisions, Mandatory and Optional Coverages)
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 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

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

$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; 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 three major recommendations:

- Reenact the no fault law, provided that additional reforms are enacted to control costs, most importantly, a medical fee schedule;
- Adopt a medical fee schedule for PIP set at a specified percentage above the Medicare fee schedule; and,
- Eliminate or limit the contingency risk multiplier as applied to attorney fee awards in PIP cases.

There were additional recommendations relating to other PIP issues, fraud, and health care clinics.

II. Effect of Proposed Changes:

Section 1. Amends s. 627.732, F.S., to provide for three new definitions under the Florida Motor Vehicle No-Fault Law. The term "*services*" is defined to mean treatment, procedures, supplies and equipment. The term "*contracted services*" means goods or services provided or performed by anyone other than a statutory employee of a supplier or provider. Under the Internal Revenue Service code, a *statutory employee*, as opposed to an independent contractor, is an employee whose employer must treat them as employees for social security tax purposes.[6] Generally the employer must withhold federal income taxes, withhold and pay social security and Medicare taxes, and pay unemployment tax on wages paid to such employee. The term "rendered" means a treatment or service which is actually performed.

Section 2. Amends s. 627.736, F.S., which applies to PIP benefits, to reorganize it 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 net income and loss of earning capacity, as a condition precedent to payment. It clarifies that if an insured elects to have disability benefits reserved for lost wages, the insured must notify the insurer in writing. 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 for properly perfected hospital liens that shall take priority over the insured's election to reserve benefits for lost wages.

In subsection (4), the bill clarifies that an injured person who is entitled to bring suit under the no-fault law has no right to recover damages for which PIP benefits are paid, payable, *or otherwise available.* The phrase, or otherwise available, refers to future PIP benefits for which a claim has not been filed. Under subsection (7), the bill clarifies that workers' compensation benefits are primary over PIP benefits. The bill also provides that a parent or legal guardian of an insured minor must, upon request of the insurer, complete an application for PIP benefits.

The bill clarifies and updates the billing and coding requirements for PIP benefits under paragraph (7)(b). 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) and 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 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

[6] For the definition of a statutory employee, see: http://www.irs.gov/publications/p15a/ar02.html.
[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.

modification and it is updated annually through a review process in order to make codes more precise due to new discoveries and medical advancements.

To determine compliance with applicable HCPCS and ICD-9-CM coding, the bill adds the National Correct Coding Initiative to the current requirements because the NCCI identifies codes that should not be billed on the same date of service (mutually exclusive codes) or without an appropriate modifier. The bill 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 to lawfully provide such services.

Under paragraph (7)(c), the bill provides that charges for personal injury protection insurance benefits may not be in excess of an unspecified percent of the maximum allowance for each procedure as set forth in the Medicare Parts A and B participating fee schedule in effect at the time services are performed for the region in which services are performed. Charges that are not compensable under the Medicare fee schedules are not compensable by the insurer. Under paragraph (7)(d) (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. Paragraph (7)(e) provides for emergency services provided under PIP. The bill requires that providers of emergency services furnish a statement of charges within 75 days of the date treatment was rendered. Currently, there is no time limitation on submission of charges. The bill also provides 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. This provision is similar to the current provision for non-emergency providers.

Under paragraph (7)(f) which provides for billing notice and disclosure, the 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 at the time of service and to require the insured to sign the written bill or similar document. Such provider must maintain a copy of the bill or document as part of the patient's medical records. Also, insurers must 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.

Subsection (8) provides new language providing procedures for a valid assignment of benefits. As stated in the Interim Report,[9] staff found that there appeared to be an inordinate amount of litigation regarding whether a properly binding assignment of benefits had been made, and which provider had priority when multiple assignment had been made. Currently, there are no clear requirements for creating a valid assignment, for determining priority of payment under multiple assignments, or for revocation of assignments to policyholders, all of which leads to uncertainty and litigation. The bill provides procedures for assigning PIP benefits and provides that an assignment to the provider by the insured is deemed a novation (meaning the provider in effect replaces the insured as far as PIP benefits are concerned). However, despite the assignment, the

[9] See pages 76-78 of the Interim Report. Staff found that injured persons assign their benefits to medical providers in the vast majority of PIP cases. Such assignments mean the injured party assigns all rights, benefits, obligations and duties to a provider for the purpose of allowing the provider to recover PIP benefits due the insured pursuant to his or her insurance policy.

insured is still responsible for required co-payments, deductibles and the provider's bills once PIP benefits are exhausted. The bill provides the wording for a valid assignment and further provides that a provider's attorney fees are not recoverable if the provider did not accept a valid assignment of benefits. In cases where the insured's obligations in a direction to pay or a letter of protection conflict with the assignment of benefits, the assignment shall void the terms of the direction to pay and letter of protection.[10]

Subsection (10) provides that all amounts repayable to an insurer include the statutory interest penalty under s. 55.03, F.S. Under the demand letter provisions of subsection (14), the bill increases the number of days an insurer has to respond to a pre-suit demand letter from 15 to 21 days. Subsection (16) requires that medical records of an injured person be available at the provider's principal place of business within 5 working days after a request for such records (if such records are maintained at an alternative location). These records shall be deemed nonexistent if not produced within that time frame. The bill clarifies which persons are subject to an examination under oath and specifies that the insurer must pay $175 per hour for attendance at such examination; however, time spent in preparation is not compensable. Once requested, an examination is a condition precedent to the filing of a law suit. The bill requires that notice to an insurer of the existence of a claim must be reported by the insured within 1 year of the accident and allows for insurers to contract that such notice may be less than 1 year.

Subsection (17) provides procedures for independent medical examinations (IMEs). The bill provides that if the insured unreasonably fails to appear for an IME, that the cost for the nonappearance, if any, shall be paid from the insured's benefits. Insurers are mandated to pay the insured for lost wages for the time missed from work as a result of attending an IME. The bill provides that during an IME, neither the insurer, the insured, nor the assignee of the insured may have counsel, a court reporter, or a videographer present.

Subsection (19) 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 (22) provides for civil monetary remedies for insurers and authorizes that an insurer may bring a civil cause of action to recover amounts paid and expenses incurred against a person presenting a PIP claim if the court determines the person knew or should have known that the claim meets specified fraudulent or other unlawful criteria. The bill removes the requirement that a person be convicted, or plead guilty or nolo contendere for insurance fraud or other crimes in order for a PIP insurer to pursue a civil action.

The bill under subsection 23 removes the monetary limitation currently placed on the amount of a reward that may be provided to persons notifying insurers of improper billing. Under subsection (24), the bill restricts venue for a PIP lawsuit to the jurisdiction where the injured party resides or where the accident occurred. If an assignment of benefits has been made, venue would be where the health care services were performed. Finally, the bill clarifies that the

[10] The bill defines both the "direction to pay" and "letter of protection." A "direction to pay" means a written instruction from the insured to the insurer directing the insurer to pay the provider directly. A "letter of protection" means an agreement between a provider and an insured wherein the provider agrees to forbear his or her right to payment in exchange for the insured's agreeing to pay the provider out of the proceeds of any settlement or judgment resulting from a bodily injury or uninsured motorist claim.

provisions under s. 627.736, F.S., (personal injury protection benefits) do not preempt or supersede any cause of action that may otherwise be available.

Section 3. Repeals s. 19 of chapter 2003-411, Laws of Florida.

Section 4. Provides that the act shall take effect October 1, 2006.

III. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

IV. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health care providers and suppliers will be compensated for their services or supplies according to a percentage of the Medicare fee schedule under the provisions of this bill. This provision should likely reduce litigation which is currently occurring under the present PIP law over payment disputes between providers and insurers as to what constitutes a "reasonable, usual and customary" charge. Applying the Medicare fee schedule will provide certainty as to all charges.

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. Insurers will now be allowed to file civil actions for certain PIP cases and obtain attorneys fees and costs. 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.

Litigation between providers and insurers should be reduced due to the provisions providing for valid assignments of benefits.

C. Government Sector Impact:

None.

V. Technical Deficiencies:

None.

VI. Related Issues:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.

VII. Summary of Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.