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 Judiciary Committee

BILL:	CS/SB 1930
INTRODUCER:	Banking and Insurance Committee and Senator Bogdanoff
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	April 22, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Fav/CS**
2.	O'Connor	Maclure	JU	**Pre-meeting**
3.			RC	
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:

The bill revises the Florida Motor Vehicle No-Fault Law (No-Fault Law) and related statutory provisions. The bill:

Motor Vehicle Fraud

- Requires the use of long-form crash reports by the law enforcement officer when passengers are in vehicles or the officer receives complaints of pain or discomfort.
- Requires written notice to applicants for clinic licensure that a fraudulent application is a fraudulent insurance act.
- Creates an auto insurance fraud direct support organization controlled primarily by appointees of the Chief Financial Officer (CFO) which can accept donations and is directed to prevent auto insurance fraud.
- Requires the suspension of an occupational license and health care practitioner license for any person convicted of insurance fraud under s. 817.234, F.S., and prohibits such persons from receiving personal injury protection (PIP) reimbursement for 10 years.
- Creates a civil penalty for motor vehicle insurance fraud authorizing civil fines of up to:
    - $5,000 for the first offense;

- $10,000 for the second offense; and
- $15,000 for third and subsequent offenses.

Investigation of Claims for No-Fault Benefits

- Defines "claimant" to include any person seeking personal injury protection (PIP) benefits, including a person that accepts an assignment of benefits from the insured.
- Allows insurers 90 days to investigate possible fraudulent insurance acts.
- Specifies that the insurer may require copies of medical treatment records to be reviewed by a medical provider within the same license chapter.
- Authorizes insurers to conduct onsite physical examinations of medical provider's offices and equipment used for treatment.
- Requires a medical provider that accepts an assignment of benefits to submit to an examination under oath (EUO) that is requested by the insurer and otherwise cooperate with the insurance investigation.
    - The insurer must pay the medical provider reasonable compensation for sitting for the EUO, and the medical provider may have an attorney present at the provider's expense.
    - An insurer that requests EUOs without a reasonable basis commits an unfair trade practice.
- Authorizes the insurer to suspend benefits upon the date an injured person fails to appear for a physical or mental examination requested by the insurer until the person appears for the examination.
    - Creates a rebuttable presumption that failure to appear for two examinations is unreasonable.
    - Provides that submitting to an examination is a condition precedent to receiving benefits.

Denial of Fraudulent No-Fault Claims

- Authorizes the insurer to deny benefits to a claimant that knowingly submits a false or misleading statement, document, bill, record, or information; or commits or attempts to commit a fraudulent insurance act.
- Authorizes the insurer to recover previous payments made to such providers that commit fraud or knowingly submit false or misleading bills, records, information, documents, or statements.
- Prohibits a provider who submitted false information or committed fraud from balance-billing the injured party for reimbursement denied by the insurer.

Submission of Bills to Insurer

- Specifies that the insured must verify treatment was rendered by countersignature, or the insurer is not provided with notice.
- Allows medical providers to resubmit an improperly completed bill or statement within 15 days after receiving notice from the insurer to submit a corrected bill.

Reimbursement of No-Fault Benefits

- Defines what constitutes an "entity wholly owned" by medical providers that is eligible to receive reimbursement for PIP treatment.
- Authorizes licensed acupuncturists to receive reimbursement for PIP treatment, but only to provide oriental medicine.
- Clarifies the PIP benefit fee schedule by specifying that the Medicare fee schedule effective on January 1 will apply for the rest of the calendar year.
- Limits reimbursement for durable medical equipment and services rendered by ambulatory surgical centers and clinical laboratories to 200 percent of Medicare Part B.
- Effective January 1, 2012, insurers must include the PIP fee schedule in their policies in order to use it.
- Preempts local lien laws favoring hospitals in accordance with the statutory requirement that the insurer reserve $5,000 to pay physicians rendering emergency treatment or inpatient hospital care.

Demand Letters

- Premature demand letters cannot be cured unless the court abates the action or the claimant files a voluntary dismissal.
- Makes a demand letter sent during a lawsuit defective.
- Prohibits using a demand letter to request documents.
- Provides 10 additional days for insurer to correct an incorrect payment in response to a demand letter.

Preferred Provider PIP Networks

- Authorizes insurers to provide a premium discount to policyholders who select a policy that provides benefits using the preferred provider (PPO) network, but specifies that the insured loses the discount once he or she uses a non-network physician, and specifies that all providers eligible for PIP reimbursement may be a part of a PPO network.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 324.021, 400.991, 456.057, 627.4137, 627.730, 627.731, 627.732, 627.736, 627.7401, and 817.234.

This bill creates section 626.9894, Florida Statutes.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's No-Fault Law, 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. 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. 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 personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, and 100 percent of replacement services for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

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.[1] 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 provided 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;
- Licensed health care clinics that are accredited by a specified accrediting organization.

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;
- 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.

[1] Chapter 2007-324, L.O.F.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. 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 co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, 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)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). 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 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007 to 2009, according to the National Insurance Crime Bureau (NICB).[4]

On April 11, 2011, the Office of Insurance Regulation (OIR) released the *Report on Review of the 2011 Personal Injury Protection Data Call*. The office received data from 31 companies that participated in a data call which covered a scope period from 2006-2010. The reporting companies cumulatively represent over 80.1 percent of the motor vehicle insurance marketplace in Florida.[5] The OIR report provides evidence that costs in the PIP system are rising rapidly:

- PIP payouts have increased from approximately $1.5 billion in 2008 to approximately $2.5 billion in 2010.
- From 2006 to 2010, the number of lawsuits pending at year-end increased by 387 percent, while the number of settlements increased 315 percent.
- Florida PIP claims involve approximately 100 medical treatments at an average total cost of $12,000, well above the national average, excluding Florida, of approximately 50 treatments at an average total cost of $8,000.
- The PIP pure premium in Florida, which is the amount of premium needed to cover losses, has increased 50 percent, from just under $100 per car in the fourth quarter of 2008 to over $150 per car in the third quarter of 2010 (the most recent period for which data was collected).
- The rise in PIP payouts and the corresponding increase in premium costs is occurring despite the fact that the number of crashes and crashes with injuries decreased from 2005 to 2009, according to the Department of Highway Safety and Motor Vehicles.

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] 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.
[4] The NICB 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.
[5] Based on 2009 Total Private Passenger Auto No-Fault Premiums reported to the National Association of Insurance Commissioners (NAIC).

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report titled *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 of Insurance Fraud during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 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:

> 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….[6]

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

- Ease of health care clinic ownership.
- 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.
- Litigation over de minimis PIP disputes.
- 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

[6] The Florida Senate, Committee on Banking and Insurance, *Florida's Motor Vehicle No-Fault Law*, Report Number 2006-102, 37-38 (November 2005), *available at* http://archive.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf (last visited April 20, 2011).

Court of Appeal ruled in *Shaw v. State Farm Fire and Cas. Co.*[7] 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. The 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 because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.[8]

Demand Letters

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of 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 of Highway Safety and Motor Vehicles within 10 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,

[7] *Shaw v. State Farm Fire and Cas. Co.*, 37 So. 3d 329 (Fla. 5th DCA 2010).
[8] *Id.* at 337 (Sawaya, J., dissenting).

including a mobile clinic and a portable equipment provider."[9] 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. As of January 20, 2011, there were 3,417 licensed health care clinics and 7,956 exemptions from licensure.

An applicant[10] for clinic licensure must submit to and pass a level 2 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 a 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.

Direct Support Organizations

A direct support 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.[11] 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.[12] 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.[13]

III. Effect of Proposed Changes:

Section 1. Amends s. 316.066(1), F.S., to require the law enforcement officer investigating a motor vehicle crash to use the Florida Traffic Crash Report Long Form if passengers are in any of the vehicles involved in the crash or any party or passenger complains of pain or discomfort. The long-form and short-form crash report must also list the names and addresses of all passengers involved in the crash and identify the vehicle in which the passenger was located. The bill also specifies that the investigating officer may testify at trial or provide a signed affidavit to confirm or supplement the information on the long-form or short-form report.

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[9] Section 400.9905(4), F.S.
[10] An applicant is any person with a 5-percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.
[11] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So. 2d 763, 769 (Fla.2005).
[12] *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. 3d DCA 1996).
[13] *See* ss. 11.45 and 215.981, F.S.

Section 2. Amends s. 400.991(6), F.S., to require an "Insurance Fraud Notice" to be included within the application for health care clinic licensure and the application for an exemption from such licensure. The notice states that submitting a false, misleading, or fraudulent application or document when applying for health care clinic licensure, seeking an exemption from licensure, or demonstrating compliance with part X of ch. 400, F.S. (the Health Care Clinic Act), is a fraudulent insurance act pursuant to s. 626.989, F.S., or s. 817.234, F.S. Such an act is subject to investigation by the Division of Insurance Fraud and grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Creates s. 626.9894, F.S., establishing the Automobile Insurance Fraud Strike Force direct support organization (DSO or organization) to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The DSO will operate under a written contract with the Division of Insurance Fraud that requires the division to approve the organization's articles of incorporation and bylaws, approve the annual budget, and certify that the DSO is complying with the terms of the contract and consistent with the goals of the Department of Financial Services (DFS) and best interests of the state. The organization's annual budget must minimize costs to the Division of Insurance Fraud by using existing personnel and property and allowing for telephonic meetings when appropriate. The DSO's contract with the Division of Insurance Fraud must provide for the allocation of monies to address motor vehicle fraud and the reversion of money and property held in trust by the organization if it ceases to exist.

The DSO must be a not-for-profit corporation under ch. 617, F.S., and use all of its grants and expenditures solely to prevent and decrease motor vehicle insurance fraud. The organization is authorized to obtain money and property necessary to conduct its mission to allocate monies to address motor vehicle fraud in the following ways:

- Raise funds;
- Request and receive grants, gifts, and bequests of money; and
- Acquire, receive, hold, invest, and administer securities, funds, and real or personal property.

The DSO may make grants and expenditures that directly or indirectly benefit the Division of Insurance Fraud, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration (AHCA), and the Department of Health. Grants or expenditures made by the organization must be used exclusively to prevent, investigate, and prosecute motor vehicle insurance fraud. Proper grants and expenditures include the salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel so long as the money does not interfere with prosecutorial independence or create conflicts of interest that threaten the prosecution's success.

Moneys received by the DSO may be held in a separate depository account in the organization's name but are subject to the written contract with the Division of Insurance Fraud. The DFS is authorized to permit the DSO to use department property without expense and is granted rulemaking authority to prescribe the procedures and conditions for use of department property. Use of grants or expenditures to lobby is prohibited and the DSO is subject to an annual financial audit. All contributions made by an insurer are allowed as an appropriate business expense for regulatory purposes.

The DSO will have a seven-member board of directors consisting of the Chief Financial Officer (CFO) (or designee), two state attorney's (the CFO and the Attorney General each appoint one), two representatives of motor vehicle insurers appointed by the CFO, and two representatives of local law enforcement agencies (the CFO and Attorney General each appoint one). Board-members serve a four-year term, until the appointing officer leaves office, or until the member ceases to be qualified. The DSO's contract must provide criteria for use by the organization's board of directors to evaluate the effectiveness of the Fund's spending to combat fraud.

Section 4. Amends s. 627.4137, F.S., which requires an insurer to provide a sworn disclosure setting forth information regarding each known policy providing liability insurance that may be available to pay a claim. The sworn statement must include the names of the insurer and each insured, the liability coverage limits, a copy of the policy, and a statement of all defenses the insurer reasonably believes it has. The bill requires that requests for the disclosure made to a self-insured corporation must be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Amends s. 627.730, F.S., to clarify that s. 627.7407, F.S., is part of the Florida Motor Vehicle No-Fault Law.

Section 6. Amends s. 627.731, F.S., to create additional intent language for the Florida Motor Vehicle No-Fault Law. Current law states that the purpose of the No-Fault Law is to require motor vehicle insurance that provides specified benefits without regard to fault, to require the registration of motor vehicles, and create a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. The bill expands upon this language by stating that the Legislature intends to balance the insured's interest in prompt claim payment with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. Accordingly, the investigation and prevention of fraudulent insurance acts must be enhanced, and additional sanctions for such acts must be imposed. The intent language also specifies how the Legislature intends the No-Fault Law to be interpreted. The No-Fault Law should be construed according to the plain language of the statutory provisions, which are designed to meet the goals specified by the Legislature.

The Legislature provides two findings of fact within the intent language. The first is that automobile insurance fraud remains a major problem for state consumers, as evidenced by the National Insurance Crime Bureau's finding that the state is among those with the highest number of fraudulent and questionable claims. The second finding of fact is that the current regulatory process for health care clinics is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance.

The intent language concludes with statements of legislative intent regarding various provisions of the bill:

- Insurers must be able to take pre-litigation examinations under oath and sworn statements of claimants and request mental and physical examinations of persons seeking PIP coverage or benefits as part of the claim investigation.

- All claims submitted by a claimant that engages in any false, misleading, or fraudulent activity are not compensable. Insurers must be able to raise fraud as a defense to a PIP claim when there has not been an adjudication of guilt or a determination of fraud by the DFS.
- Insurers should toll the payment or denial of a claim if the insurer reasonably believes that a fraudulent insurance act has been committed.
- A rebuttable presumption must be established that a person was not involved in a motor vehicle accident if that person's name is not in the police report.
- Courts should limit attorney fee awards to eliminate the incentive for attorneys to manufacture unnecessary litigation because the insured's interest in obtaining competent counsel should be balanced with the public's interest in a no-fault system that does not encourage unnecessary litigation.

Section 7. Amends s. 627.732, F.S., to define "Claimant" "Entity wholly owned" and "No-fault law" within the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7407, F.S.) as follows:

- "Claimant" means the person, organization, or entity seeking benefits, including all assignees. Medical providers that accept an assignment of benefits from the insured will be claimants under the No-Fault Law and subject to all statutory provisions related to a claimant under the law.
- "Entity wholly owned" is a proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners. To be wholly owned, the defined health care practitioner(s) must be the business owner(s) and exercise ultimate authority over personnel and compensation, be reflected as the owner(s) on the physical facility lease or ownership, file taxes as the owner(s), own the entity bank account, and be listed as the principal(s) on all incorporation documents. The definition is designed to clarify what constitutes an entity wholly owned by licensed health care providers. These entities are authorized to receive reimbursement for PIP medical services and the issue of what constitutes an "entity wholly owned" is currently the subject of litigation.
- "No-fault law" means the Florida Motor Vehicle No-Fault Law codified at ss. 627.730-627.7407, F.S.

Section 8. Amends s. 627.736, F.S., which contains the statutory provisions governing personal injury protection (PIP) insurance coverage. The bill makes numerous revisions, which are detailed and explained below.

Provider Billing Submissions – Notice of Licensure Compliance [s. 627.736(1)(a), F.S.]

A clinic or entity that initially submits a PIP claim to an insurer must include a sworn affidavit that documents that the entity or clinic is eligible to receive reimbursement for the treatment of bodily injuries covered by PIP insurance. The following entities must execute the affidavit:

- An entity that is wholly owned by one or more licensed physicians, chiropractors, or dentists or by the spouse, parent, child, or sibling of such medical practitioners.
- An entity that is wholly owned by a hospital or hospitals.
- A health care clinic licensed under part X of ch. 400, F.S.

The affidavit must be executed on a form adopted by the DFS. If the entity or clinic changes ownership, a new sworn affidavit must be provided to the insurer within 10 days.

Claim Denial – Insurer's Itemized Specification of Reduced or Denied Benefits [s. 627.736(4)(c), F.S.]

The bill states that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement. Current law requires an insurer that denies or only pays a portion of a PIP claim to provide an itemized specification of each item the insurer declined to pay or denied. The itemized specification includes information the insurer wants the claimant to consider related to the medical necessity of the treatment or to explain why the insurer was reasonable in reducing the charge, provided the information does not limit the introduction of evidence at trial.

Insurer Investigation of Possible Fraudulent Insurance Acts [s. 627.736(4)(e) & (g), F.S.]

The 30-day period for payment is tolled during the insurer's investigation of a fraudulent insurance act, as defined in s. 626.989, F.S., for any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify that claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date the insurer has a reasonable belief the act was committed. The insurer must pay or deny the claim within 90 days. Interest is calculated from the date payment is due pursuant to the 30-day payment requirement in paragraph (e) for a payment that is overdue on a claim involving the investigation of a possible fraudulent insurance act.

Pre-emption of Local Lien Laws [s. 627.736(4)(f), F.S.]

The bill preempts local lien laws and prevents them from applying to the requirement in current law that the insurer must reserve $5,000 of PIP benefits for payment to licensed physicians, licensed osteopathic physicians, and licensed dentists who provide emergency services and care or provide hospital inpatient care. Currently, local lien laws giving priority of payment to hospitals sometimes conflict with the statutory reserve.

Claim Denial – Fraudulent Insurance Acts [s. 627.736(4)(k) & (l), F.S.]

Benefits are not due to a claimant who knowingly submits a false or misleading statement, document, record, bill, or information, or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. A claimant that commits such an act is not entitled to any PIP benefits; however, a claimant that does not knowingly submit false information or commit a fraudulent insurance act may not be denied benefits solely due to such an act by another claimant. The insurer may recover sums previously paid to such claimants and bring any common law and statutory causes of action against the claimant if the fraud is admitted to in a sworn statement or established in court.

The insurer may recover any benefits or attorney's fees paid to a claimant that commits a fraudulent act or knowingly submits false or misleading documents or information. The paragraph does not preclude or limit the insurer's right to deny a claim on other evidence of

fraud and to prove a claim or defense of fraud under common law. The injured party is not liable for fraudulent acts committed by a physician, hospital, clinic, or other medical institution. A provider may not bill the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts.

Insurer Investigations – Records Review [s. 627.736(5)(a), F.S.]

The bill states that the insurer has the right and duty to reasonably investigate the claim. As part of the insurer's claim investigation, it may require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer. The records review must be conducted by a practitioner within the same licensing chapter as the medical provider whose records are being reviewed. The records review tolls the 30-day period for payment from the date the insurer sends a request for treatment records to the date the insurer receives the treatment records. The bill also provides a set fee the medical provider may charge for copying records.

Insurer Investigations – Compliance of the Insured [s. 627.736(5)(b), F.S.]

An insured seeking PIP benefits must comply with the terms of the insurance policy. Such compliance includes, but is not limited to, submitting to examinations under oath. The bill states that compliance with the terms of the insurance policy is a condition precedent to receiving benefits; accordingly, the insured will forfeit all past and future benefits if it does not comply with the terms of the policy.

Claim Denial – Grounds for Denying a PIP Claim or Refusing a Provider Billing [s. 627.736(5)(c), F.S.]

The bill specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider. The insurer may deny a claim or reduce reimbursement if the insured, claimant, or medical provider:

- Fails to cooperate in the insurer's investigation;
- Commits a fraud or material misrepresentation; or
- Fails to comply with the requirements of s. 627.736(5), F.S.

PIP Fee Schedule Applies to Durable Medical Equipment and Specified Care [s. 627.736(6)(a)1.f., F.S.]

The bill specifies that insurer reimbursement for durable medical equipment and medical care rendered by ambulatory surgical centers and clinical laboratories may be limited to 80 percent of 200 percent of the allowable amount under the Medicare Part B fee schedule. Current law contains a loophole that has resulted in the fee schedule not applying to such medical equipment and services because they are not part of the "participating physicians schedule" of the Medicare Part B fee schedule.

Claim Payments – PIP Fee Schedule [s. 627.736(6)(a)2., F.S.]

The bill clarifies the Medicare fee schedule in effect on January 1 will be the PIP fee schedule for the entire calendar year. The provision is designed to reduce unnecessary billing disputes and litigation caused by updates to the Medicare fee schedule.

Inclusion of PIP Fee Schedule Within Insurance Policy [s. 627.736(6)(a)5., F.S.]

Effective January 1, 2012, an insurer must include the statutory PIP fee schedule within the insurance policy in order to limit reimbursement payments to medical providers. The requirement is designed to eliminate future litigation regarding the use of the fee schedule by insurers that do not include it in their insurance policies.

Provider Billing Submissions – Countersignature of Billing Forms and Patient Logs [s. 627.736(6)(b)1.e., F.S.]

An insurer or insured is not required to pay a claim or charges (except for emergency treatment and care) if the insured failed to countersign a billing form or patient log related to the claim or charges. Failure to submit a countersigned billing form or patient log creates a rebuttable presumption that insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the treatment and loss until it can verify the insured received the alleged treatment.

Provider Billing Submissions –15 Day Resubmission Period [s. 627.736(6)(d), F.S.]

The bill requires an insurer that denies a claim due to the medical provider's failure to submit a properly completed statement to notify the provider which provisions of the bill or statement were not properly completed. The provider has 15 days after receipt of the notice to submit a properly completed statement or bill. If the provider fails to submit a properly completed statement or bill, the insurer is not required to provide reimbursement for the improperly billed services.

Provider Billing Submissions – Initial Disclosure Form and Patient Treatment Log [s. 627.736(6)(e), F.S.]

The bill states that an insurer does not have notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgement form is furnished to the insurer. Current law requires a medical provider providing treatment for bodily injury covered by PIP insurance to obtain at the initial treatment a disclosure form of the insured's rights that details the treatment to be provided and is signed by the injured person and subsequently countersigned by the injured person verifying that the treatment was rendered. The disclosure and acknowledgement form is not required for emergency services or for ambulance transport and treatment. The bill also states that listing Current Procedural Terminology (CPT) coding or other coding on the initial disclosure form does not satisfy the statutory requirement to describe the services rendered.

Under current law, for subsequent treatments, the provider must maintain a patient log of services rendered in chronological order. The bill requires the provider to submit a copy of the

patient log within 30 days after receiving a written request from the insurer. If the provider does not maintain a patient log, the treatment is unlawful and noncompensable. The patient log must describe subsequent services rendered in readable language; listing billing codes is not allowed.

Insurer Investigations – On-Site Inspection of Medical Provider [s. 627.736(7)(b), F.S.]

The bill authorizes each insurer to conduct an on-site physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and medical equipment used for services rendered within 10 days of the insurer's request.

Assignment of Benefits [s. 627.736(7)(b)2., F.S.]

The bill states that when a medical provider accepts an assignment of no-fault benefits from an insured, the medical provider and the insured must comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO). Compliance is a condition precedent to recovering benefits under the No-Fault Law.

Insurer Investigations – Examinations Under Oath [s. 627.736(7)(b)2.a.-c., F.S.]

The Fifth District Court of Appeal has held that under current law, a medical provider who is assigned PIP benefits by its insured is not required to submit to an examination under oath (EUO).[14] Under the bill, a medical provider that accepts an assignment of benefits must submit to an EUO upon the request of the insurer. The provider must produce the persons having the most knowledge of the issues identified by the insurer in the EUO request. The insurer must pay the medical provider reasonable compensation for attending the EUO, but expert witness fees do not constitute reasonable compensation. The provider may have an attorney present at the EUO at the provider's expense. All claimants (the person receiving treatment and the provider) must produce and provide for inspection all reasonably obtainable documents relevant to the medical services rendered that are requested by the insurer. The EUO may be recorded by audio, video, or court reporter. Unreasonably requesting EUOs as a general practice is an unfair or deceptive trade practice.

Insurer Investigations – Mental & Physical Examination of Insured [s. 627.736(8), F.S.]

Current law authorizes the insurer to require an injured person to submit to a mental or physical examination whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future PIP insurance benefits. The bill specifies that the insurer may suspend PIP benefits upon the failure of the injured person to appear for an examination until the examination occurs. The bill also creates a rebuttable presumption that the injured party's failure to appear for two examinations is unreasonable. The bill states that submission to an examination is a condition precedent to the recovery of benefits; accordingly, all past and future benefits are forfeited if the injured person does not submit to the examination.

[14] See *Shaw*, *supra* note 7.

The provision is intended to address the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 53 Fla. L. Weekly S640 (Fla. 2010). In *Custer*, the Court determined that the insurer must provide evidence that an insured's failure to appear (three times in the facts of the case) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Benefits – No-Fault Preferred Provider Networks [s. 627.736(10), F.S.]

Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" option (PPO). However, if the insured uses an "out-of-network" provider, the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law. The current PPO does little to reduce PIP costs because there is no incentive for the insured to utilize network providers and thus little incentive for medical providers to contract with the PIP insurer. Additionally, many motor vehicle insurance carriers lack the expertise to create the medical provider network necessary to offer a preferred provider option.

The bill modifies the no-fault preferred provider option by authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider. If a premium discount is provided, the insurer may restrict reimbursement of non-emergency services to members of the preferred provider network unless there are no network providers within 15 miles of the insured's place of residence. The insured forfeits the premium discount upon using a non-network provider for non-emergency services if there are qualified network providers within 15 miles of the insured's residence. The insurer may contract with a health insurer to use an existing preferred provider network, with any other arrangement subject to Office of Insurance Regulation (OIR) approval. All providers and entities eligible to receive PIP reimbursement under s. 627.736(1), F.S., are eligible to participate in a preferred provider network.

Demand Letters [s. 627.736(11), F.S.]

Under current law, the claimant must provide a written demand letter specifying the PIP benefits and amounts that the claimant asserts are due under the policy prior to filing suit. If the insurer pays the overdue claim specified in the demand letter with interest and a 10-percent penalty, the claimant may not file suit. The bill modifies the demand letter requirement as follows:

- The claimant filing suit must submit the demand letter.
- A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - A defective demand letter cannot be cured unless the court abates the action or the claimant voluntarily dismisses the action.
    - If the insurer pays the benefits during abatement or dismissal, the insurer is not liable for attorney's fees.

- If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Demand letters may not be used to request record production from the insurer.
- The bill removes the requirement that a demand letter involving future treatment must include the insurer's notice of withdrawing payment for future treatment. Under current law, the insurer may withdraw payment for a treating physician if the insurer retains a physician that performs a mental or physical examination of the patient pursuant to s. 627.736(7), F.S., and the physician reports that the treatment is not reasonable, related, or necessary.

Section 9. Amends s. 817.234, F.S., to create a civil penalty applicable to a person convicted of violating s. 817.234, F.S., for the purpose of receiving insurance proceeds for a motor vehicle insurance contract. The civil penalty is:

- A fine of up to $5,000 for the first offense.
- A fine greater than $5,000 not to exceed $10,000 for the second offense.
- A fine greater than $10,000 not to exceed $15,000 for the third offense.
- For organizing, planning, or participating in a staged accident, the fine must be at least $15,000 not to exceed $50,000.

The civil penalty does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to pay the civil penalty. Civil penalty payments must be paid to the Insurance Regulatory Trust Fund within the DFS and used for the investigation and prosecution of insurance fraud.

The section also specifies that any licensed health care practitioner or person who owns an entity eligible to receive reimbursement for PIP benefits who is found guilty of insurance fraud under s. 817.234, F.S., shall lose his or her occupational license or practice license for five years and may not receive reimbursement for PIP benefits for 10 years.

Section 10. Amends s. 324.021, F.S., by making technical, conforming changes to the definition of "motor vehicle" in the financial responsibility law.

Section 11. Amends s. 456.057(2)(k), F.S., by making a technical conforming change to a statutory reference.

Section 12. Amends s. 627.7401(1)(b), F.S., by making technical conforming changes to statutory references.

Section 13. The act is effective July 1, 2011.

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:

To the extent that the bill's provisions are effective in reducing motor vehicle insurance fraud, policyholders will benefit through a reduction in rates for such insurance.

Violators of the provisions in the bill are subject to civil penalties. Medical providers also face possible license suspension under the bill.

C. Government Sector Impact:

The Fight Auto Fraud direct support organization may increase funding to the Division of Insurance Fraud and other law enforcement agencies to combat motor vehicle insurance fraud.

The Department of Highway Safety and Motor Vehicles states that the requirement to utilize the long-form traffic crash report when passengers are involved in an accident or there are indications that a party to the accident is experiencing pain or discomfort will create additional costs for the department. Based on historical trends, this change could increase the number of long-form crash reports received by the department by approximately 90,000 per year. In 2009, the department received 76,258 short form reports that included one or more passengers involved in the accident. Based on estimates and the department's current contract for processing crash reports, the new requirements could cost the department to process the additional reports an estimated $104,687 per year. The department further estimates an additional 45,000 hours per year of time would be needed by officers of the state to complete the long form as opposed to the time it takes to complete the shot form.

VI. Technical Deficiencies:

Section 9 of the bill requires the revocation of an occupational license or the revocation of the medical provider's license for five years if a person commits of insurance fraud. The provisions revoking the license of various medical providers eligible for PIP reimbursement should be placed within the licensing chapters of the respective medical providers.

There is a typographical error on line 486 of the bill, where the word "codified" is misspelled.

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 by Banking and Insurance on April 12, 2011:
The Committee Substitute:

- Creates a civil penalty for motor vehicle insurance fraud.
- Requires the suspension of an occupational license and health care practitioner license for any person convicted of insurance fraud under s. 817.234, F.S., and prohibits such persons from receiving PIP reimbursement for 10 years.
- Allows insurers 90 days to investigate possible fraudulent insurance acts.
- Specifies that the insurer may require copies of medical treatment records to be reviewed by a medical provider within the same license chapter.
- Authorizes the insurer to suspend benefits upon the date an injured person fails to appear for a physical or mental examination requested by the insurer and creates a rebuttable presumption that failure to appear for two examinations is unreasonable.
- Requires an insurer to pay the medical provider reasonable compensation for sitting for an examination under oath and allows the medical provider to have an attorney present at the provider's expense.
- Authorizes the insurer to deny benefits to a claimant that knowingly submits a false or misleading statement, document, bill, record, or information; or commits or attempts to commit a fraudulent insurance act.
- Allows medical providers to resubmit an improperly completed bill or statement within 15 days after receiving notice from the insurer to submit a corrected bill.
- Authorizes licensed acupuncturists to receive reimbursement for PIP treatment, but only to provide oriental medicine.
- Effective January 1, 2012, insurers must include the PIP fee schedule in their policies in order to use it.
- Preempts local lien laws favoring hospitals in accordance with the statutory requirement that the insurer reserve $5,000 to pay physicians rendering emergency treatment or inpatient hospital care.

B. Amendments:

None.