HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 119 Motor Vehicle Insurance
SPONSOR(S): Economic Affairs Committee, Insurance & Banking Subcommittee, Boyd and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	10 Y, 5 N, As CS	Reilly	Cooper
2) Civil Justice Subcommittee	10 Y, 5 N	Thomas	Bond
3) Economic Affairs Committee	12 Y, 6 N, As CS	Reilly	Tinker

SUMMARY ANALYSIS

Fraud and abuse in no-fault motor vehicle insurance, personal injury protection (PIP), has led to significant increases in PIP premiums and has made the coverage unaffordable for an increasing number of Floridians. Reform efforts over the years have had varying degrees of success, but PIP fraud remains rampant. The bill revises no-fault motor vehicle insurance requirements. It modifies current PIP benefits to provide medical care coverage (MCC). To be eligible for MCC benefits, individuals must seek treatment within 72 hours of a motor vehicle accident. MCC medical benefits of up to $10,000 are available to persons who timely present at a hospital and are diagnosed (or subsequently diagnosed) with an emergency medical condition. Alternatively, MCC medical benefits of up to $1,500 are available to individuals who *either* timely present for treatment and are determined at a hospital not to have an emergency medical condition *or* who do not present at a hospital but timely seek treatment with a medical doctor, osteopathic physician, dentist, physician assistant, or advanced registered nurse practitioner. MCC retains many aspects of the PIP system, and is identical to PIP with respect to persons covered by the no-fault policy, the maximum benefit available in certain circumstances, and the availability of lost wage and funeral benefits.

The MCC law created by the bill also:

- Provides Legislative findings on fraud and abuse in the no-fault insurance system and the need for reform.
- Requires that new forms and rates be filed by insurers by December 1, 2012, to reflect the cost savings resulting from the bill.
- Creates a rebuttable presumption that a diagnosis of emergency medical condition in a hospital is correct.
- Makes compliance with all policy terms by the insured a condition precedent to eligibility for benefits.
- Tolls the 30-day payment period for an additional 30 days when fraud is suspected.
- Bars payment of any MCC benefits to persons who submit false statements or false information.
- Creates rebuttable presumption that an insured's failure to appear for two examinations (mental or physical) is an unreasonable refusal or failure to submit to examination.
- Caps attorney fee awards, and bars the use of contingency risk multipliers in no-fault disputes.

The bill provides for a single motor vehicle crash report form and requires insurers to use forms and rates that reflect the MCC Law for no-fault policies issued or renewed on and after December 1, 2012.

By providing coverage for all injuries, specifying eligible providers, and retaining the maximum $10,000 for emergency medical conditions, but limiting reimbursement for non-emergency injuries, the bill addresses cost drivers in the PIP system, and is expected to have a positive fiscal impact on motor vehicle insurance policyholders. The fiscal impact on state and local governments is unknown.

Except as otherwise provided, the bill is effective December 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Motor Vehicle Accident Reports

For motor vehicle accidents, s. 316.066, F.S., provides for the filing of a Long-Form or Short-Form Crash Report. The more detailed long-form report must be completed by a law enforcement officer only when the accident:

- Results in injury or death; or
- Involves a hit and run or intoxicated driver.

Completed long-form reports must be filed with the Florida Department of Highway Safety and Motor Vehicles (DHSMV). In other cases, a short-form report may be completed by a law enforcement officer or the parties involved in the accident. Short-form reports prepared by law enforcement officers are maintained by the local law enforcement agency and are not submitted to the DHSMV.

No-Fault Motor Vehicle Insurance

Florida's Motor Vehicle No-Fault Law (the "No-Fault Law")[1] requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. Florida is one of 12 states[2] with no-fault motor vehicle[3] insurance provisions. The purpose of the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida motorists are required to carry a minimum of $10,000 of PIP insurance and $10,000 of property damage liability coverage.[4,5]

Florida's PIP System

Legislative History

In 1971, Florida became the second state in the country to adopt a no-fault motor vehicle insurance plan, which took effect January 1, 1972. Since its enactment, various changes have been made to the No-Fault Law.

In 2000, a Statewide Grand Jury found rampant fraud in the PIP system. Reform legislation was enacted in 2001,[6] which adopted many of the Grand Jury's recommendations. These included requiring certain health care clinics to register with the Department of Health and providing criteria for medical directors; applying fee schedules for specified procedures; limiting access to motor vehicle crash reports to curtail illegal solicitation; and providing that insurers/insureds are not required to pay claims of brokers.

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[1] Sections 627.730-627.7405, F.S.

[2] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance. The systems in New Jersey, Pennsylvania, and Kentucky are sometimes separately categorized as "choice" no-fault states, as motorists in these states have the option to reject the no-fault limitation on lawsuits and retain the right to sue for their injuries. See the Insurance Information Institute's update on "No-Fault Auto Insurance." *Available at*: http://www.iii.org/media/hottopics/insurance/nofault/ (last visited Jan. 23, 2012).

[3] "Motor vehicle" is defined in s. 627.732, F.S., and includes private passenger motor vehicles and commercial motor vehicles.

[4] Section 627.7275, F.S.

[5] Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for bodily injury and property damage liability at the time of motor vehicle accidents or when serious traffic violations occur.

[6] Chapter 2001-271, L.O.F.

Additional changes were enacted in 2003.[7] These included strengthening health care clinic regulation; requiring agency licensure with the Agency for Health Care Administration (AHCA); requiring all PIP claimants to send a pre-suit demand letter to insurers for unpaid benefits; specifying criteria as to "reasonable" charges for services; strengthening various criminal penalties for PIP fraud; and providing for the repeal of the No-Fault Law on October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session.

In 2006, CS/CS/CS SB 2114, a bill that would have extended the sunset date of the No-Fault Law and made other changes, was passed by the Legislature and subsequently vetoed. The No-Fault Law then sunset on October 1, 2007.[8]

In Special Session C of 2007, the Legislature passed CS/HB 13C, which revived and reenacted the No-Fault Law effective January 1, 2008. The bill, signed into law as ch. 2007-324, L.O.F., limits medical reimbursement to services and care provided by specified health care providers and entities; authorizes insurers to use schedules of maximum charges in calculating reimbursement for medical services, supplies, and care; and provides that an insurer's failure to pay PIP claims as a general business practice is an unfair and deceptive trade practice.

Current Provisions

PIP provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. PIP benefits are payable as follows:

- 80 percent of reasonable medical expenses.
- 60 percent of loss of income.
- Death benefit of $5,000 or the remainder of unused PIP benefits, whichever is less.

PIP 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 a vehicle accident, except in the following cases:[9]

- Significant and permanent loss of an important bodily function.
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.
- Significant and permanent scarring or disfigurement.
- Death.

Lawsuits for pain and suffering may commence only if the injuries meet these threshold levels.

PIP insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue.[10] Before filing a lawsuit for overdue PIP benefits, the aggrieved person must given the insurer written notice of intent to sue.[11] If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

[7] Chapter 2003-411, L.O.F.
[8] The Motor Vehicle No-Fault Law was repealed pursuant to s. 19, ch. 2003-411, F.S.
[9] Section 627.737, F.S.
[10] Section 627.736(4)(b), F.S.
[11] Section 627.736(10), F.S.

Providers and Entities Eligible for PIP Reimbursement

Pursuant to s. 627.736, F.S., PIP provides medical reimbursement for services and care lawfully provided, supervised, ordered, or prescribed by a licensed physician, osteopath, chiropractor or dentist *or* provided by the following persons or entities:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provides emergency transport and 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;
- Licensed health care clinics that:
    - Have a medical director that is a Florida licensed physician, osteopath, or chiropractor;
    - Have been continuously licensed for more than 3 years or are publicly traded corporations; and
    - Provide at least four of the following medical specialties: general medicine; radiography; orthopedic medicine; physical medicine; physical therapy; physical rehabilitation; prescribing or dispensing outpatient prescription medication; or laboratory services.

Charges for Treatment and Services

The No-Fault law sets forth schedules of maximum reimbursement, each of which applies to specified care and services (e.g., emergency transport and treatment). For medical services, supplies, and care not addressed by a specific reimbursement schedule, the No-Fault law provides for reimbursement at 80 percent of 200 percent of the physicians schedule of Medicare Part B,[12] developed by the Centers for Medicare and Medicaid Services (CMS). Currently, CMS develops annual fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.[13]

Recent Developments: Case law

Mental and Physical Examinations of PIP Claimants

In *Custer Medical Center v. United Automobile Insurance Co.*,[14] a passenger injured in an automobile accident failed to appear for two medical examinations requested by the insurer. At the time the requests were made, the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Florida Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer on the following grounds: attendance at a medical examination is not a condition precedent to the existence of an automobile insurance policy; a dispute concerning attendance at a medical examination concerns an insured's right to receive "subsequent" PIP benefits pursuant to s. 627.736(7)(b), F.S., under an existing insurance policy, and is not a dispute about the policy's existence; additionally, s. 627.736(7), F.S., provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits. Here, it was not shown that the injured passenger's failure to attend medical examinations constituted an "unreasonable refusal" to submit to examination. Further, the claim sought payment for

[12] Medicare Part B covers doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.

[13] The Centers for Medicare and Medicaid Services, "Fee Schedules – General Information," http://www.cms.gov/FeeScheduleGenInfo/ (last visited Jan. 23, 2012).

[14] 62 So.3d 1086 (Fla. 2010).

medical services that had been provided before, and not after, the passenger failed to appear for examination.

Recent Developments: Regulatory

PIP Data Call by Office of Insurance Regulation and Subsequent Report

Early in 2011, the Florida Office of Insurance Regulation (the OIR), pursuant to s. 624.316, F.S., requested data from insurers writing personal automobile lines of business in Florida. The requested data focused on PIP claims associated with policies bearing a Florida PIP endorsement. Thirty-one companies participated in the data call, which covered a scope period from 2006-2010. Twenty-five of the participating companies represented 80.1% of the marketplace based on 2009 Total Private Passenger Auto No-Fault Premiums reported to the National Association of Insurance Commissioners.

On April 11, 2011, the OIR published "Report on Review of the 2011 Personal Injury Protection Data Call."[15] The report noted that over the past several years the number of drivers in Florida has remained stable, the number of accidents has decreased, but that the frequency and severity of PIP claims has increased significantly. Other findings include the following:

- The number of PIP claims opened or recorded in 2010 increased by 28% since 2006.
- From 2006-2010, insurers paid $8.7 billion for PIP claims and the number of PIP lawsuits pending at year end in which the insurer was the defendant increased by 387%.
- From 2008 to 2010, PIP benefits paid by insurers increased by 70% ($1.43 billion to $2.37 billion).[16]
- As of 2010, 87% of PIP claims opened originated in South Florida, Tampa/St. Petersburg, Northeast Florida, Southwest Florida, and Central Florida.
- PIP fraud is a significant issue, with Tampa, Miami, Orlando, Hialeah, and West Palm Beach having the highest numbers of staged accidents/questionable claims. Additionally, from July 1, 2007 to April 25, 2010, the number of PIP referrals to the Division of Fraud within the Department of Financial Services increased by more than 60% (from 2,669 referrals to 4,271 referrals).
- In 2010, insurers paid out over $1.04 for every premium dollar collected.
- Based on current trends, a 19% increase in PIP claims paid, a 9% increase in claim severity, and a 29% increase in pure premium can be expected this year.
- Florida exceeds the national average for number of health care provider charges per PIP claim and the average number of procedures per claim.
- For physical medicine and rehabilitation:
    - The median number of procedures per claim increased by 59% from 2006 to 2010.
    - Frequency of procedures increased 22%.
    - The amount billed increased 173% from 2008 to 2010.
    - The number of massages increased 251% from 2007 to 2010, and the amount reimbursed for massages increased 202%.
- For chiropractic treatment:
    - Median number of treatments and duration of treatment decreased by 10% and 13%, respectively, since 2007, and the median frequency has remained constant.
    - The total billed amount for chiropractic manipulative treatment increased 46% since 2007, and total allowed reimbursement increased 23%.

[15] *Available at*: www.floir.com/siteDocuments/PIP_04-08-2011.pdf (last visited Jan. 23, 2012).
[16] Presentation on PIP fraud and overview of findings of the PIP data call report by Insurance Commissioner McCarty at the Aug. 16, 2011 meeting of the Florida Cabinet. Recording of the meeting, *available at*: http://www.myflorida.com/myflorida/cabinet/agenda11/0816/audioindex.html (last visited Jan. 23, 2012).

Personal Injury Protection Working Group and Subsequent Report[17]

In September and October 2011, at a series of three meetings, a PIP Working Group assembled by the Insurance Consumer Advocate (ICA) met to discuss issues of concern in the PIP system. In addition to the ICA, the working group included representatives of various system stakeholders, including hospitals, medical doctors, osteopaths, chiropractors, insurers, and attorneys. The group heard presentations on PIP fraud, results of the OIR's PIP data call, benefits and disadvantages of the current no-fault system, health care clinic licensure (and exemptions from licensure) and fraud, independent medical examinations, and delivery of emergency services, among other matters.

At the conclusion of these meetings, the ICA, in December 2011, published "Report on Florida Motor Vehicle No-Fault Insurance (*Personal Injury Protection*)." The report contains data and information collected from various sources, including the OIR, National Association of Insurance Commissioners, Insurance Research Council, National Insurance Crime Bureau, Mitchell International, Inc., other state agencies, etc. Among the reported findings:

- Strains and sprains were the most serious injury reported by 70% of PIP claimants.[18]
- The number of PIP claimants treated in emergency room settings declined from 57% in 1997 to 54% in 2007.[19]
- In 2010, average charges per PIP claimant (by provider) were lowest for emergency medicine ($1,613). The highest average charges per PIP claimant were by chiropractors ($3,482), acupuncturists ($3,674), and massage therapists ($4,350).[20]
- The number of new massage therapist licenses increased from 2,843 in 2010 to an estimated 4,892 in 2011.
- The percentage of PIP claimants visiting chiropractors increased from 30% in 1997 to 43% in 2007.[21]

Attorney Fee Awards to "Prevailing Claimants" in Litigation Against Insurers

Lodestar Calculation

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court calculates the lodestar, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[22]

In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar:[23]

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.

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[17] Meeting materials, presentations and Personal Injury Protection Working Group Report available at: http://www.myfloridacfo.com/ICA/PIPWorkingGroup.htm (last visited Jan. 23, 2012).

[18] Insurance Research Council, "PIP Claiming Behavior and Claim Outcomes in Florida's No-Fault Insurance System," Feb. 2011, based on claims data for 2007.

[19] Analysis updated in Insurance Research Council, "PIP Claiming Behavior and Claim Outcomes in Florida's No-Fault Insurance System," p.11, Feb. 2011.

[20] Analysis based on information secured from Mitchell International Inc. that is representative of approximately 70% of the current Florida PIP insurer market share.

[21] Insurance Research Council, "Florida Auto Injury Insurance Claim Environment 2007 Final Report," Feb. 2007.

[22] The federal lodestar approach to determining fee awards was adopted by the Florida Supreme Court in *Florida Patient's Compensation Fund v. Rowe*, 472 So.2d 1145 (Fla. 1985).

[23] *See* Rule 4-1.5(b) of the Rules Regulating the Florida Bar.

- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

Contingency Risk Multiplier

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the lodestar in determining the fee award.[24] For example, if the lodestar were $20,000 and the court determined it appropriate to apply a contingency risk multiplier of 2.5, the fee award would be $50,000 ($20,000 lodestar x 2.5).

The Florida Supreme Court, in *Florida Patient's Compensation Fund v. Rowe*,[25] authorized the use of contingency risk multipliers in personal injury cases on two grounds:

- It provides personal injury claimants with increased access to courts.
- Since attorneys working on a contingency fee basis are not paid if they do not prevail, they must charge more for their services than an attorney who is guaranteed payment.

Subsequently, in *Standard Guaranty Insurance Co. v. Quanstrom*,[26] the Court clarified that use of a contingency risk multiplier was not mandatory, but was within the trial court's discretion.

In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[27]

Currently, there is a split of authority between the First and Fifth District Courts of Appeal with respect to the evidence required to support the use of a contingency risk multiplier in calculating a fee award under s. 627.428, F.S. In *Progressive Express Insurance Co. v. Schultz*,[28] the 5th DCA held that use of a contingency risk multiplier in a PIP action was improper because the policyholder did not testify that he had any difficulty obtaining legal representation, there was no evidence presented on the issue, and the lawsuit was essentially a straightforward contract case involving $1,315. In *Massie v. Progressive Express Insurance Co.*,[29] the issue before the 1st DCA was whether use of a contingency risk multiplier was proper when the PIP claimant did not testify that she had difficulty obtaining counsel, but expert testimony was offered that the claimant would have had such difficulty without the opportunity for a multiplier. On direct appeal, the Circuit Court reversed the trial judge, relying on *Schultz,* holding that the use of a multiplier was improper, and the claimant petitioned for certiorari review. Based on its own precedent, the 1st DCA granted the petition, quashed the order on direct appeal, and affirmed the trial court's use of a contingency risk multiplier based on expert testimony.

Effect of Bill

Legislative Findings

The bill sets forth Legislative findings relating to fraud and abuse in the PIP system and the need for reform. Specifically, the Legislature finds that:

- The objectives of the PIP system, to deliver medically necessary treatment and care promptly and without regard to fault with minimal litigation, has been frustrated by fraud and abusive practices.
- PIP fraud has become pervasive and has cost Florida motorists and their insurers approximately $1.3 billion since 2009.

[24] *Standard Guaranty Insurance Co. v. Quanstrom*, 555 So.2d 828 (Fla. 1990).
[25] 472 So.2d 1145 (Fla. 1985).
[26] 555 So.2d 828 (Fla. 1990).
[27] *See Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[28] 948 So.2d 1027 (Fla. 5th DCA 2007).
[29] 25 So.3d 584 (Fla. 1st DCA 2009).

- PIP premiums have risen to unacceptable levels and without reform will double every three years.
- PIP losses from fraud and abuse are increasing faster than the rise in premiums, threatening the availability and affordability of PIP coverage.
- Significant reforms are required to curtail fraud in the no-fault motor vehicle insurance system.
- Ensuring the availability and affordability of no-fault motor vehicle insurance by requiring medical care coverage is an overwhelming public necessity and provides a commensurate benefit.

Motor Vehicle Crash Reports

The bill provides for a single crash report form, rather than a long-form report and a short-form report. In addition to other required information, a completed form must clearly identify the driver of each vehicle, the passengers, and the vehicle in which each passenger was traveling. For motor vehicle accidents that result in death, personal injury, or involve a driver who leaves the accident scene or is driving under the influence, the crash report must be submitted to the Florida Department of Highway Safety and Motor Vehicles, but may also be maintained by the law enforcement officer's agency. All other crash reports are to be maintained by the law enforcement officer's agency.

No-Fault Motor Vehicle Insurance

The bill revises no-fault motor vehicle insurance requirements in Florida, modifying personal injury protection coverage (PIP) to provide medical care coverage (MCC) for no-fault policies issued or renewed on and after December 1, 2012. MCC narrows the no-fault insurance mandate, making the maximum medical benefit payable dependent on the severity of the injury sustained. MCC is identical to PIP with respect to persons covered by the no-fault policy, the maximum medical benefit payable for certain injuries ($10,000), and the availability of lost wage and funeral benefits. The bill also retains, with varying degrees of change, many aspects of the PIP system (demand letters, schedule of maximum charges, etc.). The bill provides that it is the Legislature's intent that the provisions, schedules, and procedures of the MCC Law be given full force and effect, regardless of their inclusion in an insurer's forms, on the effective date of the bill.

No-fault insurers will continue to use current forms and rates for all policies issued or renewed before December 1, 2012. All forms and rates for policies issued or renewed on or after this date must reflect the provisions of the MCC Law and must be approved by the OIR prior to being used.

The following provides an overview of significant features of the MCC Law.

Mandatory Insurance Coverage

Florida motorists are required to secure and maintain $10,000 of no-fault, medical care coverage insurance (MCC insurance) and $10,000 of property damage liability insurance. Insurers may not require motorists to purchase other types of motor vehicle insurance or coverage in amounts greater than that required by law.

MCC Insurance

MCC insurance provides up to $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. MCC insurance benefits are payable as follows.

- Up to a limit of $10,000, 80 percent of reasonable medical expenses for:
    1) Emergency transport and treatment rendered by a licensed ambulance provider within 24 hours after the motor vehicle accident.

2) "*Emergency services and care*"[30] rendered within 72 hours after the motor vehicle accident in a licensed hospital.
3) Services and care rendered when an insured is admitted to a hospital within 72 hours after the motor vehicle accident.
4) Services and care rendered to an insured who is determined more than 72 hours after the motor vehicle accident to have an "*emergency medical condition*"[31] related to the initial diagnosis and arising from the motor vehicle accident.
5) If the insured receives services and care pursuant to 2), 3), or 4), subsequent services and care directly related to the determination of an emergency medical condition and medical diagnosis arising from the accident, subject to the following;
    a) The medical diagnosis and determination of emergency medical condition must be rendered in a hospital and rendered by a physician, osteopathic physician, dentist or, to the extent permitted by applicable law and under the supervision of such provider, by a physician assistant or advanced registered nurse practitioner.
    b) The care and services must be rendered by any of previously specified providers.
6) If the insured receives services and care pursuant to 2), 3), 4), or 5), all medically necessary medical, surgical, dental, nursing, or diagnostic ancillary services, hospital or ambulatory surgical center services, durable medical equipment, prosthetics or orthotics and supplies.

- Up to a limit of $1,500, 80 percent of all reasonable expenses for:
    1) Services and care rendered within 72 hours of the motor vehicle accident by a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or 459, or an advanced registered nurse practitioner licensed under chapter 464.
    2) If the insured receives services and care pursuant to 1), subsequent services and care rendered by a provider listed therein and directly related to the medical diagnosis arising from the motor vehicle accident.
    3) All medically necessary medical, surgical, dental, nursing, or diagnostic ancillary services, hospital or ambulatory surgical center services, durable medical equipment, prosthetics or orthotics and supplies.
    4) Payment of benefits of up to $1,500 under 1), 2), or 3) shall occur only if a person has been determined in a hospital to not have an emergency medical condition or the person did not present herself or himself at a hospital but received treatment from a provider identified in 1) within 72 hours of the motor vehicle accident
- 60 percent of loss of income.
- Death benefit of $5,000 or the remainder of unused MCC benefits, whichever is less.

For purposes of the MCC law, a medical diagnosis made in a hospital that an emergency medical condition exists is presumed to be correct, unless rebutted by clear and convincing evidence to the contrary.

MCC insurance provides the policyholder with immunity from liability for covered injuries; for economic damages (medical expenses) up to the $10,000 policy limits, and for non-economic damages (pain and suffering). 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 a vehicle accident, except in the following cases:

[30]Emergency services and care means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exits, and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

[31] Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, including a pregnant woman or fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, an emergency medical condition exists when there is inadequate time to effect safe transfer to another hospital prior to delivery; when a transfer may pose a threat to the health and safety of the patient or fetus; or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

- Significant and permanent loss of an important bodily function.
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.
- Significant and permanent scarring or disfigurement.
- Death.

Lawsuits for pain and suffering may commence for covered injuries only if the injuries meet these threshold levels.

Payment of Benefits

MCC insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue. Before filing a lawsuit for overdue MCC benefits, the aggrieved person must give the insurer written notice of intent to sue. If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

If an insurer has reasonable belief that a fraudulent insurance act, as defined in s. 626.989 or s. 817.234, has been committed, the 30-day payment period is tolled as to any portions of the claim being investigated. The insurer, within 30 days of receipt of written notice of a covered loss and the amount of the loss, must notify the insured in writing that the claim is being investigated for suspected fraud. The insurer must pay or deny the claim within 90 days after being provided with written notice of the claim and the amount of the loss. For claims that are paid, interest is assessed from the day the insurer received the claim to the date of payment. When payment is not made within 90 days, legal action may be brought against the insurer without service of a pre-suit demand letter.

MCC benefits are not due or payable to or on behalf of an insured, claimant, provider, or attorney, if such person has:

- Submitted a false material statement, document, record, or bill.
- Submitted false material information.
- Otherwise committed or attempted to commit a fraudulent insurance act.

Persons who commit such acts are precluded from receiving any MCC benefits relating to the claim, including payment for bills or services, regardless of whether a portion of the claim is legitimate. Medical providers cannot be denied payment for services rendered solely due to the misconduct of another person.

Examinations Under Oath

Insureds are required to comply with all terms of the MCC policy including, but not limited to, submitting to an examination under oath (EUO). The scope of questioning under an EUO is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with policy terms is a condition precedent to the receipt of benefits. An insurer that, as a general business practice, as determined by the OIR, requests EUOs without a reasonable basis commits an unfair and deceptive trade practice.

Medical Reimbursement under the MCC Law

Medical providers and entities may charge the insurer and injured party only a reasonable amount for services and care rendered. Payments made by insurers pursuant to the schedule of maximum charges are considered reasonable. If a provider bills a lesser amount, and the insurer pays the amount billed, the payment is also considered reasonable. Insurers that provide reimbursement under the schedule of charges may use all Medicare coding policies and CMS payment methodologies, including applicable modifiers to determine the appropriate amount of reimbursement for medical services, supplies, or care.

The MCC Law permits reimbursement at 80% of the following schedule of maximum charges:

- For emergency transport and treatment by licensed providers, 200 percent of Medicare.
- For emergency services and care provided by a licensed hospital, 75 percent of the hospital's usual and customary charges.
- For emergency services and care provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.
- For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.
- For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital or ambulatory surgical center providing the outpatient services.
- For all other medical services, treatment, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For medical services, treatment, supplies, and care provided by clinical laboratories, 200 percent of the allowable amount under Medicare Part B. For durable medical equipment, the amount contained in the Durable Medical Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule of Medicare Part B. However, if such services, treatment, or supplies, and care are not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13, F.S., and rules adopted thereunder that are in effect at the time such services, treatment, supplies, or care are provided. Services, treatment, or supplies that are not reimbursable under Medicare or workers' compensation are not required to be reimbursed by the insurer.

In calculating reimbursements under the schedule of maximum charges, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation that was in effect as of March 1st of the year in which the services, treatment, supplies, or care were rendered, and applies until March 1st of the following year, regardless of any subsequent changes to such fee schedule or payment limitation. However, the reimbursement amount may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, treatment, supplies, and care subject to Medicare Part B.

Upon receipt of notice of an accident that is potentially covered by MCC insurance, an insurer must reserve, and hold for 30 days, $5,000 of MCC benefits for payments to specified health care providers who provide emergency services and care coverage.

Insurers are authorized to request and conduct onsite physical reviews and examinations of the treatment locations and medical equipment of medical providers and entities that submit claims for payment of MCC benefits.

Sanctions Against Non-compliant Insurers

Insurers that, as a general business practice, request examinations under oath without a reasonable basis, fail to pay medical care coverage claims, or engage in other specified misconduct are subject to sanction for committing unfair and deceptive acts or practices. The bill provides that the OIR is responsible for investigating non-compliance with the no-fault motor vehicle law and determining if an insurer's conduct constitutes an unlawful general business practice that subjects the insurer to sanctions.

Examinations (Mental or Physical) of the Insured

When an insured unreasonably refuses to submit to or fails to appear at an examination (mental or physical) requested by the insurer, the MCC insurer is not liable for subsequent MCC benefits. An insured's refusal or failure to appear for two examinations (mental or physical) is presumed to be an

unreasonable refusal or failure to submit to examination. The presumption, however, is rebuttable, and may be overcome by the claimant upon showing that refusal or failure to attend was not unreasonable.

Limitations on Attorney Fee Awards

The use of contingency risk multipliers in calculating fee awards in no-fault MCC disputes is prohibited. Fee awards in no-fault litigation are limited to the lesser of the actual fee incurred based upon a rate for attorney services not to exceed $200 per billable hour or:

- For any disputed amount of less than $500, 15 times any disputed amount recovered by the attorney, limited to $5,000.
- For any disputed amount of $500 or more and less than $5,000, 10 times any disputed amount recovered by the attorney, limited to a total of $10,000.
- For any disputed amount of $5,000 or more and up to $10,000, 5 times any disputed amount recovered by the attorney, limited to a total of $15,000.

Attorney fee awards in a class action are limited to the lesser of $50,000 or three times the total of any disputed amount recovered in the class action proceeding.

Fees incurred in litigating or quantifying the amount of fees due to the prevailing party under the MCC Law are not recoverable.

These limitations on attorney fee awards are effective upon the bill becoming law.

B. SECTION DIRECTORY:

Section 1. Amends s. 316.066, F.S., effective May 1, 2012, relating to motor vehicle crash report forms.

Section 2. Amends s. 627.736, F.S., to provide limitations on attorney's fees in no-fault disputes.

Section 3. Creates s. 627.748, F.S., providing for ss. 627.748-627.7491, F.S., to be referred to as the Florida Motor Vehicle Medical Care Coverage Law (MCC Law); providing Legislative findings.

Section 4. Creates s. 627.7481, F.S., providing the purposes of the MCC Law.

Section 5. Creates s. 627.74811, F.S., providing the effect of the law on MCC policies.

Section 6. Creates s. 627.7482, F.S., providing definitions.

Section 7. Creates s. 627.7483, F.S., providing for required security for Florida motorists.

Section 8. Creates s. 627.7484, F.S., providing for proof of security.

Section 9. Creates s. 627.7485, F.S., providing required benefits under MCC policies.

Section 10. Creates s. 627.7486, F.S., providing tort exemption for injuries under the MCC law.

Section 11. Creates s. 627.7487, F.S., providing for optional deductibles under MCC policies.

Section 12. Creates s. 627.7488, F.S., providing for a notification of rights to insureds under the MCC Law.

Section 13. Creates s. 627.7489, F.S., requiring mandatory joinder of certain MCC claims.

Section 14. Creates s. 627.749, F.S., providing insurer's right to reimbursement for MCC benefits under specified circumstances.

Section 15. Creates s. 627.7491, F.S., providing for application of the MCC Law.

Sections 16 to 49. Amends ss. 316.646, 318.18, 320.02, 320.0609, 320.27, 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032, 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072, 626.9541, 627.06501, 627.0652, 627.0653, 627.4132, 627.6482, 627.7263, 627.727, 627.7275, 627.728, 627.7295, 627.8405, 627.915, 628.909, 705.184, 713.78, and 817.234, F.S., to conform and correct cross-references.

Section 50. Directs the Division of Statutory Revision to replace the phrase "the effective date of this act" wherever it occurs in this bill with the date the bill becomes law.

Section 51. Provides a severability clause.

Section 52. Provides an effective date of December 1, 2012, except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate. Florida imposes a 1.75% premium tax on the gross insurance premiums collected by every insurance company. The tax is subject to numerous deductions. The tax is paid into the General Revenue Fund. In FY 2010-11, premium taxes of $482.5 million were paid into the General Revenue Fund. This sum represents the premium tax from all forms of insurance, it is unknown how much premium tax results from PIP coverage. It is anticipated that this bill will lower insurance premiums and correspondingly decrease collections of the insurance premium tax. The potential fiscal loss to the state is unknown. It is also possible that consumers may purchase additional insurance offsetting some of this loss.

2. Expenditures:

   The bill will create workload for the Office of Insurance Regulation (OIR), as motor vehicle insurers will be required to file new rates and forms with the OIR for approval.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The Department of Highway Safety and Motor Vehicles reports it is unclear what impact the new traffic form requirements will have on local law enforcement agencies. The use of “long form” traffic accident reports by various local law enforcement agencies may require more time per accident investigation.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that MCC policies provide a medical benefit of up to $1,500 for non-emergency conditions, rather than $10,000 as under current law, the MCC Law will assist in lowering the premiums paid by Florida motorists for no-fault motor vehicle insurance.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or, reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

The bill limits attorney fees in no-fault motor vehicle insurance cases. Attorney fee limitations have been upheld against a variety of constitutional challenges, including challenges to equal protection, due process, separation of powers, access to courts, and the right to contract. [32]

B. RULE-MAKING AUTHORITY:

The Financial Services Commission is required to adopt by rule a standard disclosure and acknowledgment form. The commission is also required to adopt by rule a form for the notification of insureds of their right to receive emergency care coverage.

The Department of Health (DOH) is authorized to adopt by rule a list of diagnostic tests deemed not to be medically necessary for purposes of treatment under no-fault motor vehicle insurance.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 11, 2012, the Insurance & Banking Subcommittee considered and adopted a proposed committee substitute substantially changing the bill from one modifying PIP to one substituting emergency care coverage for PIP.

On February 24, 2012, the Economic Affairs Committee considered and adopted a proposed committee substitute to CS/HB 119 to provide no-fault coverage for emergency and non-emergency medical conditions arising from motor vehicle accidents. The analysis has been updated to reflect the changes made by adoption of the PCS.

[32] For example, fee limitations in workers' compensation have been upheld as constitutional. *See, e.g., Lundy v. Four Seasons Ocean Grand Palm*, 932 So.2d 506, 510 (Fla. 1st DCA 2006) (upholding a provision limiting attorney fees in workers' compensation cases). The First DCA rejected the allegation that the provision denied access to courts or encroached upon the judicial powers, violated the Equal Protection and Due Process clauses, or impermissibly restricted the right to contract, stating: "The claimant's argument is unpersuasive….The claimant has failed to demonstrate that the statute has unduly burdened a claimant's ability to retain counsel in order to secure benefits, or that the statute limits the types of benefits a claimant is authorized to pursue under [the workers' compensation law]." The *Lundy* decision was disapproved of by *Murray v. Mariner Health*, 994 So.2d 1051 (Fla. 2008), but the Florida Supreme Court, deciding the case under rules of statutory interpretation, never addressed the constitutional claims in that decision. In 2011, the First DCA, in *Kauffman v. Community Inclusions, Inc.*, 57 So.3d 919 (Fla. 1st DCA 2011), recognizing the *Murray* decision, did not address such constitutional issues, reaffirmed its reasoning in *Lundy*, and rejected "equal protection, due process, separation of powers, and access to courts challenges."