HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1819 (PCB IN 03-01a) Motor Vehicle Insurance
SPONSOR(S): Committee on Insurance, Representative Berfield
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1202

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Regulation (Sub)	10 Y, 0 N	Cheek	Schulte
2) Insurance	16 Y, 0 N	Cheek	Schulte
3)			
4)			
5)			

SUMMARY ANALYSIS

In recent years, Florida motorists have faced rising premiums for motor vehicle insurance and the companies writing motor vehicle insurance have faced rising losses. The increases in premiums and losses are frequently attributed to insurance fraud and problems with the no-fault system. HB 1819 addresses the problem of motor vehicle insurance affordability. Major changes from current law are as follows:

Fraud: Increases penalties for solicitations of accident victims and fraudulent insurance applications; provides minimum mandatory penalties for intentional motor vehicle crashes and certain solicitations of accident victims; prohibits intentional motor vehicle crashes; makes selling, making, or presenting a fraudulent insurance card and selling used parts as a new felony; provides that submitting a bill for "upcoded" or "unbundled" services, services not performed, or making use of confidential crash reports to solicit patients constitutes grounds for disciplinary action only when intentional and only in the context of a PIP claim; provides additional resources for the Division of Insurance Fraud; allows insurers and insureds to maintain civil actions for fraud; provides legal entitlement; and prohibits third-party disclosure for crash reports.
Medical Costs: Creates an independent dispute resolution process addressing the reasonableness of provider fees and proper use of billing codes.
Attorney Fees: Provides standards to be used in court in determining whether to apply a multiplier to attorney's fees and in determining the amount of the multiplier.
Clinics: Prohibits convicted criminals from being employed by or owning an interest in a clinic; requires additional information for registration and background screening; exempts entities owned by licensed facilities from clinic registration; provides that services, with the exception of licensed facilities, must be billed only by a physician; requires medical directors to have had an unencumbered record for at least 5 years; requires due diligence on all employees; allows full access by the Department of Health; and requires mobile clinics to be subject to regulation as clinics.
Accountability Reporting: Requires the Office of Insurance Regulation to provide semi-annual reports to the Legislature on the impact of these reforms. Requires the Division of Insurance Fraud to provide reports on the same schedule on violations, investigations, and prosecutions.
Sunset: Provides for repeal of the no-fault law effective October 1, 2005, unless reenacted by the 2004 Legislature.

HB 1819 bill does not appear to have a substantial fiscal impact on state or local government.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

B. EFFECT OF PROPOSED CHANGES:

HB 1819 addresses the rising cost of motor vehicle insurance in Florida. It makes substantial changes to the no-fault auto insurance system, cracks down on motor vehicle insurance fraud, tightens regulation of clinics that exist primarily to treat crash victims, and provides the Legislature with the tools necessary for increased oversight of the system.

Background

History of Florida no-fault auto insurance

Under Florida's no-fault automobile insurance system, all drivers must obtain insurance that covers their own injuries and their passengers' injuries in motor vehicle accidents without regard to which driver is at fault. This coverage is known as Personal Injury Protection (PIP). A person is allowed to sue for damages beyond the limits of no-fault coverage only with respect to specified, serious injuries.

This system was created in 1971 and revised extensively through the 1970s. The Legislature has, however, enacted relatively few changes to the no-fault law in the last 25 years. Insurance companies suggest that while the statute has remained relatively stable, a series of court-made changes to the law have weakened the ability of the no-fault system to keep insurers' losses and consumers' costs under control. The growth of insurance fraud has been cited by the Fifteenth Statewide Grand Jury, the Division of Insurance Fraud of the Department of Financial Services, insurance companies, and others as another cause of rising losses and rising automobile insurance premiums.

Rising premiums and loss costs

In 1999, Florida's auto insurance premiums ranked 19th in the nation, with average premiums for full coverage (PIP, property damage liability, bodily injury liability, collision, and other-than-collision) of $800. Since 1999, many insurers have been approved for two rounds of premium increases of approximately 10 percent and 15 percent.

In the last two years, loss costs have risen dramatically. Florida PIP loss costs rose by 22.1 percent in the 2000-2001 period (the last period for which full-year data are available). During the same period, Florida bodily injury liability loss costs rose by 15.8 percent.

From 1999 through 2002, 52 insurance companies became insolvent. The inability to cover losses from no-fault coverage was the primary cause of most of these insolvencies, according to insurance regulators.

2000 Statewide Grand Jury Report

The Fifteenth Statewide Grand Jury investigated PIP fraud in 2000. The grand jury concluded that the $10,000 no-fault coverage is a "personal slush fund" for certain legal and medical professionals. They determined that fraud starts with the solicitation of motor vehicle accident victims on behalf of unscrupulous health care providers and attorneys. The solicitation source document is the motor vehicle crash report.

The grand jury discovered that unethical medical professionals contribute to the problem by padding bills, charging inflated fees, charging for services never rendered, ordering unnecessary tests, etc. The grand jury found that the lack of a statutory definition of what is a reasonable and necessary treatment or charge adds to the problem. Patients often do not realize the size of their medical bills because they often assign payment rights directly to the provider. One chiropractor testified to the grand jury that he hired a technician to conduct nerve conduction studies at $100 and billed the no-fault insurer $900. Chiropractors, the grand jury learned, also use video fluoroscopy even though it is not medically indicated. These unethical chiropractors rent the machines for $1,500 per month and charge $650 for each session. Unethical attorneys refer patients to chiropractors who always find a permanent injury for purposes of pain and suffering suits, thwarting the intent of the tort threshold to reduce court congestion regarding small injury cases.

Seven Recommendations from the 2000 Statewide Grand Jury Report

The Statewide Grand Jury developed seven recommendations for legislative action. The majority of these became law in the 2001 Legislative Session (see chapter 2001-271, Laws of Florida). The seven recommendations from the 2000 Statewide Grand Jury Report can be summarized as:

- Prohibit the release of crash reports to anyone other than the victim;
- Increase the penalty for illegally using the information found in crash reports;
- Mandatory registration of medical facilities;
- Fee schedule;
- Allow insurers 30 extra days to investigate if fraud is suspected;
- Prohibit MRI brokering and allow insurers not to pay MRI bill if from a broker; and
- Insurer not required to pay if service rendered is part of an illegal solicitation.

While the 2001 no-fault insurance fraud legislation has proven helpful, it was never thought to be the ultimate fraud, abuse, and over-utilization solution. Rather, insurers accepted the changes for what they were, a first step. Two years after these changes, fraud, abuse, and over-utilization continue to be rampant. To effectively combat no-fault insurance fraud, it will be necessary to remove the incentive to commit fraud (one-sided, unfair litigation environment, lack of an objective standard for insurers to determine the reasonableness and necessity of bills submitted for payment, and a broken dispute resolution mechanism) and to make the penalty for committing fraud severe.

Current Status of Fraud Problem

According to the Department of Financial Services, Division of Insurance Fraud, the vast majority of PIP fraud involved solicitation of accident victims and staged accidents. Organized fraud rings use "runners" to obtain accident reports from law enforcement agencies and then solicit persons involved in these accidents on behalf of unscrupulous attorneys and doctors. Once recruited, the accident victim is sent to an attorney who refers the person to a medical provider or clinic where he or she receives a battery of unnecessary tests. According to the division, most of these tests often exhaust the insured's $10,000 PIP coverage benefit and position the attorney to improperly sue the insurer. Other "rings" stage vehicular accidents in order to defraud the PIP system. The proposed committee bill provides several reforms to combat fraud, to enhance penalties for those found guilty of "milking" the automobile

insurance system, and to provide investigative resources to the Division of Fraud within the Department of Financial Services.

Major Changes from Current Law

HB 1819 makes the following major changes:

- Solicitation of accident victims:

  - ✓ Provides that solicitation of a person involved in a motor vehicle accident with intent to defraud is a second-degree felony, increased from a third-degree felony, with a 2-year minimum mandatory sentence. The court is allowed to waive the minimum mandatory sentence with respect to a person who has provided substantial assistance to the prosecution.

  - ✓ Provides that any solicitation, for the purpose of making a PIP claim within 60 days of a vehicle accident, except for advertising, a third-degree felony.

  - ✓ Provides that any solicitation more than 60 days after an accident by specified professionals (e.g., lawyers, chiropractors, medical providers, or owners of medical directors of clinics) at the victim's residence in person or by telephone contact, is a second-degree felony.

  - ✓ Provides that "charges" for services rendered by a person who violates the above solicitation prohibitions are not compensable by the insurer or insured.

  - ✓ Amends the Offense Severity Ranking Chart law (s. 921.0022, F.S.) to increase the ranking of the following crimes: soliciting an accident victim with intent to defraud; unlawfully obtaining or using a confidential crash report; filing a false motor vehicle insurance application; operating an unregistered clinic or filing false registration information; and organizing, planning, or participating in an intentional motor vehicle collision.

  - ✓ Prohibits those who lawfully possess confidential or exempt information contained in police reports to solicit victims or their family members.

  - ✓ Requires that any person attempting to access confidential crash reports, within 60 days from the date the report is filed must show photographic identification, proof of their exempt status, and sign a sworn statement stating that no confidential information from any crash report would be used for any commercial solicitation or disclosed to any third party for the purpose of such solicitation for the period of time that the crash report remains confidential.

  - ✓ Applies certain anti-solicitation provisions to all health care practitioners by applying these requirements to chiropractors and medical providers.

- "Upcoded" or "unbundled" services

  - ✓ Provides that submitting a bill for "upcoded" or "unbundled" services, services not performed, or making use of confidential crash reports to solicit patients constitutes grounds for disciplinary action only in the context of a PIP claim and requires intent.

- Intentional Motor Vehicle Crashes:

    - ✓ Provides that it is a second-degree felony to organize, plan, or participate in an intentional motor vehicle collision; requires a 2-year minimum mandatory sentence. The court is allowed to waive the minimum mandatory sentence with respect to a person who has provided substantial assistance to the prosecution.

- False or fraudulent motor vehicle insurance application/insurance card:

    - ✓ Upgrades the penalty for filing a false or fraudulent motor vehicle application from a first-degree misdemeanor to a third-degree felony.

    - ✓ Creates the crime of making, selling, or presenting a false or fraudulent insurance card; provides a third-degree felony penalty for the violation.

- Fraudulent charges for repairs or parts:

    - ✓ Upgrades the penalty from a first-degree misdemeanor to a third-degree felony for overcharging for repairs and parts when the charges are to be paid from the proceeds of a motor vehicle insurance policy.

- Sale of used parts as new:

    - ✓ Creates the crime of selling used parts as new when the charges are to be paid from the proceeds of a motor vehicle insurance policy; provides a third-degree felony penalty to sell used motor parts as new.

- Additional resources for Division of Insurance Fraud:

    - ✓ Requires convicted individuals to pay restitution to the Department of Financial Services for the benefit of the Division of Fraud Fund.

- Civil actions by victims:

    - ✓ Allows insurers and insureds to maintain civil actions to recover damages from insurance fraud.

    - ✓ Allows an insurer and an insured to sue for treble damages in a civil action for insurance fraud.

- Effect of fraud on insurance coverage:

    - ✓ Provides that PIP fraud voids the entire motor vehicle insurance policy and that benefits are not due with respect to fraudulent claims.

- Access to crash reports:

    - ✓ Requires presentation of proper identification to prove identity and entitlement to a confidential vehicle crash report.

    - ✓ Provides that crash reports be made available to the parties, legal representatives, insurers and agents, or other persons under contract, only after proper identification and proof of the claimed status is provided.

Tort Threshold

- Risk multipliers (attorney's fees):

  ✓ Provides standards to be used by a court in determining whether to apply a multiplier to attorney's fees and in determining the amount of the multiplier.

- Dispute Resolution (provider fees):

  ✓ Creates an independent dispute resolution process addressing the reasonableness of provider fees and proper use of billing codes.

Billing

✓ Provides additional detail on requirements for proper billing of insurers.

✓ Requires a statement to be signed by a patient and a physician under oath that specified services were rendered on the day they were rendered. Requires the physician to maintain the record and make it available for inspection.

Examinations

✓ Requires the physician performing an independent medical examination to maintain certain records for at least 3 years.

Fee Schedule

✓ Provides that amounts charged for MRI services provided in facilities accredited by both the American College of Radiology and the Joint Commission on Accreditation of Health Care Organizations cannot exceed 225% of the Medicare Fee schedule

✓ Defines the "participating" Medicare schedule as part of the Medicare fee schedule that applies for a billing purposes

✓ Specifies that the consumer price index to be applied to the Medicare fee schedule is as of January each year

Disqualified Persons

✓ Amends the definition of "disqualified person" to limit disqualifications based on convictions to convictions that occurred within the previous 10 years.

Mediation

✓ Expands applicability of current mediation provisions.

Statute Of Limitations

✓ Provides a 2-year statute of limitations for actions to enforce PIP benefits.

Demand letter; offer of judgment

✓ Applies current law on demand letters and offer of judgment to all PIP claims.

- ✓ Expands the provisions of the current pre-suit demand letter (s. 627.736(11), F.S.) to be applicable to all PIP disputes and increase the time for insurers to respond to the letter from 7 business days to 10 business days.

Clinics

According to the Department of Health, health care clinic registration requirements need to be tightened to prevent unscrupulous owners and other connected with such clinics from defrauding the PIP system. The Department of Health primarily regulates professions, not health care entities, and they lack the requisite expertise, investigative staff, and enforcement authority to adequately regulate clinics. Specifically, the proposed committee bill:

- Accreditation
  - ✓ Provides that every clinic and subsequent providers engaged in MRI services must be accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations.
  - ✓ Provides for accreditation and notification to insurance companies of accreditation
  - ✓ Requires that an insurer not demand a copy of the certificate of accreditation from each clinic if it has been previously provided, so long as the clinic certifies that it maintains its accreditation.
  - ✓ Prohibits an insurer from denying payment to an MRI clinic based on failure to comply with accreditation requirements which the insurer can prove it was not provided with the required certification.
- Involvement of convicted criminals:
  - ✓ Requires owners of clinic (no matter what percentage of ownership) and clinic medical directors to have no prior disciplinary, civil, or criminal sanctions imposed within the past 5 years. If such a sanction has been imposed, the individual or entity may not own or serve as medical director of a clinic. If such sanction is discovered after registration, the clinic must dismiss the offender, face sanctions, and amend its registration.
- Registration and enforcement:
  - ✓ Tightens overall clinic registration provisions by allowing the Department of Health to do background investigations and perform on-site unannounced inspections, to utilize emergency authority to close a clinic for specific violations, and to utilize other administrative tools to regulate clinic activity. Requires clinics to amend their registrations if material changes occur.
  - ✓ Makes it a third-degree felony for any person convicted of knowingly filing a false or misleading clinic registration application or who files false or misleading information pertaining to the registration.
  - ✓ Exempts entities owned by licensed facilities, such as hospitals, from clinic registration requirements and provisions requiring that services must be billed only by a physician.
  - ✓ Provides that the Division of Insurance Fraud of the Department of Financial Services may assist the Department of Health in investigating medical clinics that do no comply with regulatory requirements.

- Disqualified employees:

  - ✓ Requires medical directors to have had a clean record for at least 5 years (no convictions, no disciplinary action).

  - ✓ Requires a clinic to conduct due diligence on all employees.

- Medical Records

  - ✓ Requires the physician performing an independent medical examination to maintain certain records for at least 3 years.

- Access by regulatory agency:

  - ✓ Mandates that clinics allow full and complete access by the Department of Health to the premises and to all records.

- Status of mobile clinics:

  - ✓ Requires registration of all mobile health care clinics.

Global Diagnostic Imaging

- ✓ Defines "Global Diagnostic imaging billing" which is the process for billing both the technical and professional component for an imaging charge.

- ✓ Provides that global diagnostic imaging billing is not "upcoded," to prohibit denial of bills submitted by a provider under the global diagnostic imaging billing.

- ✓ Prohibits denial of bills submitted by a global diagnostic imaging provider.

- ✓ Creates a definition for a diagnostic imaging center as distinguished from clinics that render other services.

- ✓ Requires payment of charges submitted by an IDTF to conform with the definition of ""diagnostic imaging center"

- ✓ Excludes IDTF from acknowledgement of treatment requirement to conform with the definition of ""diagnostic imaging center"

Accountability Reporting

- ✓ Requires the Office of Insurance Regulation to provide semi-annual (January 1 and July 1) reports to the Legislature on the impact of these reforms, including loss cost trends and rate trends. Requires the Division of Insurance Fraud to provide reports on the same schedule as violations, investigations, and prosecutions.

Sunset

- ✓ Provides for a report no later than January 1, 2004 evaluating the costs and benefits of PIP insurance, repeals the No-Fault Law effective October 1, 2005, unless re-enacted by the Legislature in the 2004 regular session, and provides for notification oaf the real to policyholders/.

C. SECTION DIRECTORY:

Section 1: Provides findings and purpose for the Florida Motor Vehicle Insurance Affordability Reform Act of 2003.

Section 2: Amends s. 95.11, F.S. - *Limitations other than for the recovery of real property*

Section 3: Amends s. 119.105, F.S. – *Protection of victims of crimes or accidents*

Section 4: Amends s. 316.066, F.S. – *Written reports of crashes*

Section 5: creates s. 408.7058, F.S., providing an independent dispute resolution process addressing the reasonableness of provider fees and proper use of billing codes.

Section 6: Amends s. 456.0375, F.S. – *Registration of certain clinics; requirements; discipline*.

Section 7: Amends s. 456.057, F.S.- *Ownership and control of patient records; report or copies of records to be furnished*

Section 8: Amends s. 456.072, F.S. – *Grounds for discipline; penalties; enforcement*

Section 9: adds s. 627.732, F.S. – *Definitions*

Section 10: Amends s. 627.736, F.S. – *Required personal injury protection benefits; exclusions; priority; claims*,

Section 11: Amends s. 627.745, F.S. – *Mediation of claims*

Section 12: Creates s. 627.747, F.S. – *Legislative oversight; reporting of information*

Section 13: Amends 768.79, F.S. - *Offer of Judgment and demand for judgment*

Section 14: Amends s. 817.234, F.S. - *False and fraudulent insurance claims*

Section 15: Amends s. 817.236, F.S. – *False and fraudulent motor vehicle insurance application*

Section 16: Creates s. 817.2361, F.S. – *False or fraudulent motor vehicle insurance card*

Section 17: Creates s. 817.413, F.S. – *Sale of used motor vehicle goods as new; penalty*

Section 18: Amends s. 860.15, F.S. – *Overcharging for repairs and parts*

Section 19: Amends s. 921.083, F.S. – *Criminal punishment code; offense*

Section 20: Specified legislative intent of the amendment to s. 456.0375(1)(b)1., F.S., - *Registration of certain clinics; requirements; discipline; exemptions,* to provide a retroactive effective date.

Section 21: Provides for a report no later than January 1, 2004 evaluating the costs and benefits of PIP insurance, repeals the No-Fault Law effective October 1, 2005, unless re-enacted by the Legislature in the 2004 regular session, and provides for notification of the repeal to policyholders.

Section 22: Provides that the act takes effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill allows the Department of Health to adopt rules necessary to implement the registration program, including rules establishing the specific registration procedures, forms, and fees. The fees are to be calculated to cover the cost of registration, but not to exceed the cost of administering and enforcing compliance. Therefore, the Department of Health will be able to collect fees to cover its costs that would result in a neutral impact.

The bill also provides for payment of restitution to the Division of Insurance Fraud.

2. Expenditures:

The Office of Insurance Regulation is required to provide semi-annual (January 1 and July 1) reports to the Legislature on the impact of these reforms, including loss cost trends and rate trends. The Division of Insurance Fraud is required to provide reports on the same schedule as violations, investigations, and prosecutions. There may be a minimal cost associated with the reporting requirements; however, the requirement could possibly be outsourced by the direct support organization.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If motor vehicle insurance fraud and litigation are reduced as intended by PCB IN 03-01, insurers' loss costs may decrease and auto insurance premiums may decrease.

Clinics will be required to furnish additional information for registrations and background screenings. Insureds and insurers would not be required to pay for services of clinics that are in violation of requirements.

Mobile health care clinics would require registration.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

Not Applicable.

1. Applicability of Municipality/County Mandates Provision:

Not Applicable.

2. Other:

B. RULE-MAKING AUTHORITY:

The proposed committee bill allows the Department of Health to adopt rules necessary to implement the registration program, including rules establishing the specific registration procedures, forms, and fees.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The House General Counsel has reviewed this bill and determined that, under Article I, section 24(c) of the Florida Constitution, the provisions relating to access to crash reports (Sections 1 and 3) are required to be in a separate bill relating only to public records.

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IV. **AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES**

None.