HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1819 Motor Vehicle Insurance
SPONSOR(S): Committee on Insurance and Berfield
TIED BILLS: None **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) Judiciary		Billmeier	Havlicak
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 felony offense; 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 personal injury protection (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 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;
- Establish a 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 appears 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. This 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:

Changes in Criminal Law

Section 3 of this bill requires persons who have access to confidential information in accident reports to keep that information confidential. It prohibits such persons from using that information to solicit accident victims or their family members.

Section 4 of this bill requires that any person attempting to access confidential crash reports within 60 days from the date the report is filed to show photographic identification, proof of their exempt status, and sign a sworn statement stating that no confidential information from any crash report will 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.

Section 14 makes various changes to criminal statutes relating to the solicitation of accident victims. This bill 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.

This bill 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. It provides that any solicitation more than 60 days after an accident by specified professionals such as 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. "Charges" for services rendered by a person who violates the solicitation prohibitions are not compensable by the insurer or insured.

This bill provides that it is a second-degree felony to organize, plan, or participate in an intentional motor vehicle crash. It 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.

Section 15 of this bill changes the penalty for filing a false or fraudulent motor vehicle application from a first-degree misdemeanor to a third-degree felony.

Section 16 of the bill creates the crime of making, selling, or presenting a false or fraudulent insurance card with the intent to deceive. Violation of this new section is a third-degree felony.

Section 17 provides that it is unlawful for the seller to misrepresent that goods are new or original when they are used or repossessed or have been used for sales demonstration in any transaction for which any charges will be paid from the proceeds of a motor vehicle insurance policy and in which the purchase price of motor vehicle goods exceeds $100. Violation of this section is a third-degree felony.

Section 18 of this bill increases the penalty from a second-degree misdemeanor to a third-degree felony for overcharging for repairs and parts if the charges are to be paid from the proceeds of a motor vehicle insurance policy.

Section 19 of this bill amends the Offense Severity Ranking Chart to incorporate new crimes created by this bill and changes to penalties for existing crimes.

Additional Resources for Division of Insurance Fraud

Section 14 of this bill requires convicted individuals to pay restitution to the Department of Financial Services for the benefit of the Division of Fraud Fund.

Tort Issues

Section 2 of this bill provides that the statute of limitations for PIP benefits shall run for 2 years from the time the cause of action is discovered or should have been discovered. In State Farm Mutual Automobile Insurance Company v. Lee,[1] the Florida Supreme Court held that the statute of limitations in a PIP case runs for five years from when the insurer refuses to pay and not from the date of the accident.

Section 11 of the bill provides that either party in a PIP case may demand mediation prior to the institution of litigation. Current law permits such a demand only in claims less than $10,000.

Section 13 of the bill clarifies that the offer of judgment statute applies in PIP cases. In U.S. Security Insurance Co. v. Cahuasqui,[2] the Third District Court of Appeals held 2-1 that the offer of judgment statute applied in PIP cases. This bill will prevent other district courts from reaching a contrary result.

Section 10 of the bill allows insurers and insureds to maintain civil actions to recover damages from insurance fraud and allows an insurer and an insured to sue for treble damages in a civil action for insurance fraud. The bill further provides that neither an insurer nor an insured are precluded from bringing a civil cause of action to recover payments for services later determined to have been not lawfully rendered.

The bill 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. The factors the court must consider include:

> (a) Whether the relevant market requires a contingency fee multiplier to obtain competent counsel;
> (b) Whether the attorney was able to mitigate the risk of nonpayment in any way; and
> (c) Whether any of the following factors are applicable:
>
> > 1. The time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly;
> > 2. The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
> > 3. The fee customarily charged in the locality for similar legal services;
> > 4. The amount involved and the results obtained;
> > 5. The time limitations imposed by the client or by the circumstances;
> > 6. The nature and length of the professional relationship with the client;
> > 7. The experience, reputation, and ability of the lawyer or lawyers performing the services; and
> > 8. Whether the fee is fixed or contingent.

If the court determines that a multiplier is appropriate, and if the court determines that success was more likely than not at the outset, the court may apply a multiplier of 1 to 1.5. If the court determines that the likelihood of success was approximately even at the outset, the court may apply a multiplier of 1.5 to 2.0. If the court determines that success was unlikely at the outset of the case, the court may apply a multiplier of 2.0 to 2.5.

[1] 678 So. 2d 818 (Fla. 1996).
[2] 760 So. 2d 1101 (Fla. 3rd DCA 2000).

Section 10 of the bill also repeals mandatory arbitration provisions of s. 627.736(5), F.S., that were declared unconstitutional in Nationwide Mutual Fire Insurance Company v. Pinnacle Medical Inc.[3] as a violation of the access to courts provision of the Florida Constitution.

Dispute Resolution

Section 5 of the bill creates a dispute resolution process addressing the reasonableness of provider fees and proper use of billing codes. It provides that the Agency for Health Care Administration may contract with an independent third party resolution organization to resolve claims relating to the proper coding of a charge or the reasonableness of the amount paid. Either party may refuse to participate in the process by filing a statement indicating it will not participate. If the parties use the process, the parties are required to submit documentation to support the claim to the resolution organization. The resolution organization must resolve the dispute in a timely manner and the Agency for Health Care Administration must adopt the resolution in a final order. The bill provides for payment of interests and penalties based on the decision of the resolution organization as follows:

> (1) In the event that the resolution organization finds that any charge or charges submitted on the claim are not reasonable but that the highest reasonable charge or charges are more than the amount or amounts paid by the insurer, the insurer shall pay the additional amount found to be reasonable, together with interest, a penalty of 10 percent of the additional amount found to be reasonable, subject to a maximum penalty of $250, and the entirety of the review costs.
>
> (2) In the event that the resolution organization finds that the charge or charges submitted on the claim are reasonable, the insurer shall pay the additional amount or amounts found to be reasonable, together with interest, a penalty of 20 percent of the additional amount found to be reasonable, subject to a maximum penalty of $500, and the entirety of the review costs.
>
> (3) In the event that the resolution organization finds that the amount or amounts paid by the insurer are equal to or greater than the highest reasonable charge, the insurer shall not be liable for any interest or penalties, and the health care practitioner shall be responsible for the entirety of the review costs.

If the insurer has paid the highest reasonable amount or amounts, together with the interest and penalties, if applicable, then no civil action by the health care practitioner shall lie against the insurer on the basis of the reasonableness of the charge or charges, and no attorney's fees may be awarded for legal assistance related to the charge or charges.

Documents relating to the dispute resolution process and the Agency's final order are admissible in any civil action. This bill requires the Agency for Health Care Administration to adopt rules to implement this process.

Medical Records

Section 7 of this bill requires the physician performing an independent medical examination pursuant to s. 627.736, F.S., to maintain certain records. The bill requires health care practitioners to keep on record a statement for each visit to be signed by both the patient and the health care practitioner at the time services are rendered. Such statement shall be certified under oath, subject to the penalty of perjury and prosecution for insurance fraud, that the services were in fact rendered for the patient on the date certified, that the provider has complied and will comply with the terms of s. 456.054, F.S., that the patient neither received nor will receive remuneration in any form from the practitioner or any other person for the visit, and that no other person was compensated or will be compensated in any form for referring the patient to the practitioner unless specifically permitted under s. 456.054, F.S.

[3] 753 So. 2d 55 (Fla. 2000).

Billing

Section 10 of the bill amends s. 627.736, F.S., to clarify billing requirements. It requires the provider and the insured to execute a form indicating that the services billed were actually rendered.

"Upcoded" or "Unbundled" Services

Section 8 of this bill provides that, PIP cases, submitting a bill for "upcoded" or "unbundled" services, submitting a bill for services not performed, or making use of confidential crash reports to solicit patients constitutes grounds for disciplinary action.

Effect of Fraud on Insurance Coverage

Section 10 of the bill provides that PIP fraud voids the entire motor vehicle insurance policy and that benefits are not due with respect to fraudulent claims. It provides that the insurer may recover costs and attorney's fees if it prevails in enforcing a claim under that section.

Examinations

Section 10 of the bill requires the physician performing an independent medical examination to maintain certain records for at least 3 years.

Fee Schedule

Section 10 of the bill 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. It defines the "participating" Medicare schedule as part of the Medicare fee schedule that applies for a billing purposes and 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.

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, section 5 of the bill deals with the following issues relating to the regulation of clinics:

Accreditation

It 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.

It provides for accreditation and notification to insurance companies of accreditation

It 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.

It 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.

Registration and Enforcement

The bill 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. It requires clinics to amend their registrations if material changes occur.

The bill makes it a third-degree felony for any person to knowingly file a false or misleading clinic registration application or who file false or misleading information pertaining to the registration.

Section 5 of this bill 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.

The bill 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

The bill prohibits disqualified persons from participating in the business of the clinic. It defines a "disqualified person" as any individual who, within the last 10 years, has been convicted of a felony or entered a plea of guilty or nolo contendere to a felony.

Payments to Clinics

Section 10 of the bill provides that insurers or insureds are not required to pay claims or charges for services or treatment by a clinic that is not in compliance with s. 456.0375, F.S., or rules adopted under that section. Insurers and insureds do not have to pay claims or charges to a clinic if a person who directly or indirectly owned or controlled the clinic or had any interest in the clinic had been convicted of a felony.

Access by Regulatory Agency

The bill mandates that clinics allow full and complete access by the Department of Health to the premises and to all records.

Global Diagnostic Imaging

Section 9 of this bill defines "global diagnostic imaging billing" as the submission of a statement or a bill related to the completion of a diagnostic imaging test that includes a charge that includes both the production of the diagnostic image and the interpretation of the image.

Section 10 of the bill prohibits denial of bills for global diagnostic imaging submitted by the provider of the technical component.

Section 5 of the bill creates a definition for a diagnostic imaging center as distinguished from clinics that render other services.

Section 10 of the bill excludes IDTF from the acknowledgement of treatment requirement to conform with the definition of "diagnostic imaging center."

Accountability Reporting

The bill 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. It requires the Division of Insurance Fraud to provide reports on the same schedule as violations, investigations, and prosecutions.

Retroactive Effect

Section 20 of this bill provides that this bill's amendments to s. 456.0375(1)(b)1., F.S., relating to the ownership of clinics, are intended to clarify legislative intent and apply retroactively to October 1, 2001.

Sunset

Section 21 of this bill requires the Office of Insurance Regulation to submit a report to the Speaker of the House of Representatives and the President of the Senate evaluating the costs and benefits of the PIP system. This report must be submitted by January 1, 2004.

This bill 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.

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: Amends 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. 921.0022, 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:

Comments by the staff of the Committee on Insurance:

If motor vehicle insurance fraud and litigation are reduced as intended by this bill, 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.

3. Other:

Constitutional issues raised by this bill are discussed below.

Single Subject Issues

Article III, s. 6, Fla. Const., requires every "law shall embrace but one subject and matter shall properly connected therewith, and the subject shall be briefly expressed in the title." This bill contains provisions relating to statutes of limitations, public records, clinic regulation, insurance regulation, and crimes relating to insurance fraud. It can be argued that this bill contains more than one subject.

In Heggs v. State,[4] the Florida Supreme Court explained that simply because legislation addresses a comprehensive subject does not mean it violates the single subject rule:

> In each of those cases, the Legislature specifically identified a broad crisis that it was attempting to address through the passage of the comprehensive chapter laws at issue. See Burch, 558 So.2d at 2-3 (involving challenge to chapter 87-243, Laws of Florida, in which the Legislature identified crisis in increasing crime rate); Smith, 507 So.2d at 1085-87 (involving challenge to chapter 86-160, Laws of Florida, in which the Legislature identified crisis in the availability of commercial liability insurance); Chenoweth, 396 So.2d at 1124 (involving challenge to chapter 76-260, Laws of Florida, in which the Legislature identified crisis in the tort law/medical malpractice liability insurance system); Lee, 356 So.2d at 282- 83 (involving challenge to chapter 77-468, Laws of Florida, in which the Legislature identified crisis in tort law/automobile insurance system).

In Burch v. State,[5] the court explained:

[4] 759 So. 2d 620, 627 (Fla. 2000)
[5] 558 So. 2d 1, 2-3 (Fla. 1990)

> This constitutional provision, however, is not designed to deter or impede legislation by requiring laws to be unnecessarily restrictive in their scope and operation. This Court has consistently held that wide latitude must be accorded the legislature in the enactment of laws...
>
> In Chenoweth v. Kemp, 396 So. 2d 1122 (Fla.1981), we debated whether chapter 76-260, Laws of Florida, was unconstitutional because it contained provisions covering medical malpractice, tort litigation, and insurance reform. Holding that the act did not violate article III, section 6, we said:
>
> > [T]he subject of an act "may be as broad as the Legislature chooses as long as the matters included in the act have a natural or logical connection."
>
> …
>
> The fact that several different statutes are amended does not mean that more than one subject is involved. There is nothing in this act to suggest the presence of log rolling, which is the evil that article III, section 6, is intended to prevent. In fact, it would have been awkward and unreasonable to attempt to enact many of the provisions of this act in separate legislation.

Section 1 of the bill contains legislative findings. These findings explain how the Legislature has attempted to address the problem of fraud in the motor vehicle insurance market in the past and note the problems that still exist. The findings explain that the "purpose of this act is to restore the health of the market and the affordability of motor vehicle insurance by comprehensively addressing issues of fraud, clinic regulation, and related matters." It can be argued that this bill does not violate the single subject provision because each of the sections relate to the bill's purpose of motor vehicle insurance affordability reform and the legislature has made a specific finding that comprehensive reform is necessary.

Public Records Issues

Article I, s. 24(c), Fla. Const., provides that certain bills relating to public records must be in a separate bill:

> The legislature shall enact laws governing the enforcement of this section, including the maintenance, control, destruction, disposal, and disposition of records made public by this section, except that each house of the legislature may adopt rules governing the enforcement of this section in relation to records of the legislative branch. Laws enacted pursuant to this subsection shall contain only exemptions from the requirements of subsections (a) or (b) and provisions governing the enforcement of this section, and shall relate to one subject.

This bill contains provisions restrictions on how persons who obtain motor vehicle crash reports can use that information. It also sets new conditions that must be met before a person can obtain crash reports. There is no case law interpreting the provision requiring that laws enacted pursuant to art. I, s. 24(c), Fla. Const., so whether public records issues can be included in a comprehensive bill on automobile insurance affordability is an open question.

First Amendment Issues

In State v. Bradford,[6] the Florida Supreme Court considered the First Amendment issues involved in unlawful solicitation statutes. In Bradford, the court considered the following statute:

> It is unlawful for any person… to solicit any business… for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by § 627.736. Any person

[6] 787 So. 2d 811 (Fla. 2001).

> who violates the provisions of this subsection commits a felony of the third degree, punishable as provided in §§ 775.082, 775.083, or 775.084.[7]

Bradford argued that the statute was an impermissible restriction on commercial speech and that it violated the First Amendment limitations on laws restricting the freedom of speech. The court explained the applicable test:

> Statutes or regulations which restrict commercial speech are analyzed under the framework established by the United States Supreme Court in Central Hudson Gas & Electric Corp. v. Public Service Commission. Under the Central Hudson test, the State may regulate commercial speech relating to unlawful activities, and commercial speech that is misleading. Commercial speech which does not fall into either of those categories, however, may still be regulated if the State meets its burden of establishing the following three related requirements. First, the State must establish a substantial interest in support of the restriction on commercial speech. Second, the State must also show that the restriction directly and materially advances that substantial interest. Finally, the State must demonstrate that the regulation is narrowly tailored.[8]

The court held that while the State established a substantial interest, it did not show that the restriction on speech "directly and materially" advanced that interest.[9] The court also held that the statute was not narrowly tailored because it captured a great deal of legal conduct which was unrelated to the interest in preventing insurance fraud.[10] The court explained:

> Moreover, given the nature of the inquiry in relation to this prong of the constitutional test, we must consider whether there are less restrictive measures which the State may employ in an effort to curtail insurance fraud. One very obvious less restrictive manner with which to prevent insurance fraud would be to include "intent to defraud" as an element of 817.234(8). The Legislature could have easily done so, yet it decided to not include such element in defining the prohibited conduct.[11]

It can be argued that this bill avoids the constitutional problems discussed in Bradford because it adds an "intent to defraud" provision to the unlawful solicitation statute.

The bill also contains the following provision:

> It is unlawful for any person to solicit or cause to be solicited any business from a person involved in a motor vehicle accident, by any means of communication other than advertising directed to the public, for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736, within 60 days after the occurrence of the motor vehicle accident.

The bill also provides:

> It is unlawful for any attorney, or health care practitioner as defined in s. 456.001, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, to solicit or cause to be solicited any business from a person involved in a motor vehicle accident, by means of any personal or telephone contact at the person's residence, other than by mail or by advertising directed to the public, for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736.

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[7] Bradford, 787 So. 2d at 817.
[8] Bradford, 787 So. 2d at 820 (citations and footnotes omitted).
[9] See Bradford, 787 So. 2d at 820-23.
[10] See Bradford, 787 So. 2d at 823-28.
[11] Bradford, 787 So. 2d at 827-28.

Violation of either of these provisions is the third degree felony. These provisions raise similar First Amendment issues to those raised by the earlier provision. It can be argued that these provisions are more narrowly tailored than the provision struck down in Bradford. This first provision prohibits the solicitation within 60 days of the accident rather than imposing a blanket ban like the ban imposed in Bradford. In Florida Bar v. Went For It, Inc.,[12] the United States Supreme Court upheld a 30 day prohibition on using direct mail to solicit accident victims found in the Rules of Professional Responsibility. Opponents of this provision could argue it is not narrowly tailored because it creates a crime, rather than a rule of professional conduct like what was approved in Went For It. The second provision is limited to attorneys and health care providers and only prohibits solicitation by personal or telephone contact at the person's residence. It can be argued that this restrictions are narrowly tailored to prevent insurance fraud.

B. RULE-MAKING AUTHORITY:

This 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:

Potential Unintended Consequences of the Bill

Lines 1461-1513 create a second degree felony for anyone who organizes, plans, or in any way participates in an intentional motor vehicle crash. This language would criminalize conduct that is currently legal. For example, accident reconstruction engineers or persons studying automobile safety occasionally conduct crash testing, where they organize and carry out intentional motor vehicle crashes under controlled conditions to determine safety information about vehicle or to provide information to litigants in tort cases. Since the language in this provision of the bill does not have an "intent to defraud" element, it could criminalize conduct that the Legislature might not intend to criminalize.

IV. **AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES**

None.

[12] 515 U.S. 618 (1995).