The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Banking and Insurance Committee

BILL:	CS/SB 1880
INTRODUCER:	Banking and Insurance Committee and Senator Posey
SUBJECT:	Florida's Motor Vehicle No-Fault Insurance Law
DATE:	March 29, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	**Fav/CS**
2.			JU	
3.			GA	
4.			RC	
5.				
6.				

I. Summary:

In 2003, the Legislature repealed the Florida Motor Vehicle No-Fault law.[1] The law provided that the repeal will take effect October 1, 2007, unless the provisions are reenacted by the Legislature.[2] In November 2005, the Senate Committee on Banking and Insurance published *Florida's Motor Vehicle No-Fault Law* (Interim Project Report 2006-102).[3] The report recommended the Legislature reenact the no-fault law and establish a medical fee schedule based on a percentage of Medicare, along with additional reforms.

This bill provides for the following:

- Reenacts Florida's No-Fault Law, but provides for future repeal on January 1, 2009;
- Allows insurers, under coverage for personal injury protection (PIP), to apply a maximum limit on charges equal to 200 percent of the reimbursement allowed under the Medicare Part A (hospital insurance) or Medicare Part B (medical insurance) participating fee schedule in effect at the time for the region where the treatment is provided;
- If the treatment or services are not reimbursable under the Medicare fee schedules, insurers may apply a maximum limitation that is equal to the maximum reimburseable allowance under workers' compensation;

[1] The affected sections are: ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S. Insurers are authorized to provide, in all policies issued or renewed after October 1, 2006, that such policies may terminate on or after October 1, 2007.

[2] Section 19, ch. 2003-411, L.O.F.

[3] See report *available at* http://www.flsenate.gov/data/Publications/2006/Senate/reports/interim_reports/pdf/2006-102bilong.pdf .

- If the treatment or services are not reimbursable under either Medicare or workers' compensation, they are not reimbursable by the insurer. However, this does not allow the insurer to apply any limit on the number of treatments or other utilization limits that apply under Medicare or workers' compensation;
- Prohibits a provider from billing or attempting to collect from an insured any amount in excess of the fee schedule payment limit, other than amounts not covered by the insured's PIP coverage due to deductibles, coinsurance amounts, or maximum policy limits; and
- Removes existing fee schedules for specified medical procedures.

This bill amends the following section of the Florida Statutes: 627.736.

II. Present Situation:

Florida's Motor Vehicle No-Fault Insurance Law
In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan.[4] The no-fault reform was offered as a viable replacement for the tort system as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault.

Under current law, motorists are required to purchase personal injury protection (PIP) and property damage (PD) liability coverages. The no-fault coverage, referred to as PIP, provides $10,000 of coverage for the following: payment of 80 percent of reasonable medical expenses, 60 percent of loss of income, plus a $5,000 death benefit, for bodily injury sustained in a motor vehicle accident, without regard to fault. Personal injury protection covers the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the insured motor vehicle. This coverage also provides the policyholder with immunity from liability for economic damages (medical expenses and lost wages) to the extent not covered by PIP and for non-economic damages (pain and suffering) for most injuries.

The immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of the vehicle accident, except in the following cases:
(1) significant and permanent loss of an important bodily function;
(2) permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement;
(3) significant and permanent scarring or disfigurement; or
(4) death.

This is known as the "verbal threshold" which means that suits for pain and suffering may commence only if injuries meet these levels of seriousness.

Current law also requires vehicle owners to obtain $10,000 in property damage (PD) liability coverage which pays for the physical damage expenses caused by the insured to third parties in the accident. Additionally, under Florida's Financial Responsibility law, motorists must provide proof of ability to pay monetary damages for bodily injury liability (BI) and PD liability after

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

motor vehicle accidents or serious traffic violations. The minimum amounts of liability coverage are $10,000 in the event of injury to one person, $20,000 for injury to two or more persons, and $10,000 property damage, or $30,000 combined single limits. Many drivers purchase "optional" coverages in addition to mandatory insurance including bodily injury liability, (which may be required by the Financial Responsibility Law), uninsured motorist, collision, comprehensive, medical payments, towing, rental reimbursement and accidental death and dismemberment. Insurers may not require motorists to purchase any of these optional coverages.

The Legislature enacted significant no-fault reforms in 2001 and 2003;[5] however, according to many stakeholders, these reforms have not gone far enough in resolving the problems within the no-fault system which include fraud, abuse, inappropriate medical treatment, inflated claims, inadequate compensation to victims, increased premiums, and the proliferation of law suits. As a result of these concerns, in 2003 the Legislature repealed the Motor Vehicle No-Fault law to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session and such reenactment becomes law to take effect for policies issued or renewed on or after October 1, 2006.

PIP Premiums and Loss Costs

According to data obtained from the Insurance Services Office (ISO), the average amount paid in PIP losses in Florida for each insured vehicle increased 25 percent from 2000 (4th quarter) to 2005 (4th quarter). This period saw a relatively steep rise from 2000 to 2002 and a more moderate increase from 2002 to 2005. However, PIP loss costs decreased 10.8 percent from 2005 (4th quarter) to 2006 (3rd quarter). The trend in these loss costs are not as favorable in comparison to other PIP states or no-fault states. The 2006 interim report of the Banking and Insurance Committee found that in 2000, the Florida average PIP loss costs were 13.2 percent above the average of the 17 states[6] that provide PIP coverage, but by 2005 (2nd quarter), the Florida loss costs were 69.7 percent greater than the 17-state average. More recent data from ISO compares Florida PIP loss costs with the 10 states[7] identified by ISO as no-fault states, which shows Florida's costs to be more closely in line, but which still show Florida's trend in loss costs outpacing the average. In 2001 (4th quarter), Florida average PIP loss costs were 8 percent below the average of the 10 no-fault states, but by 2006 (3rd quarter), Florida's PIP loss costs were 3.5 percent above the average.

PIP premiums charged by insurers vary across the state depending upon the insured's driving history, status as first-time driver, gender, age, credit history, insurance coverage, limits and deductibles as well as the year and type of vehicle driven, usage of the vehicle and territory.[8] The Department of Financial Services provided Committee staff with examples of annual PIP premiums in three Florida cities in 2006 for nine major auto insurers in the chart below.[9]

[5] Chapters 2001-271, L.O.F., 2001-163, L.O.F., and 2003-411, L.O.F.

[6] Delaware, Florida, Hawaii, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New York, North Dakota, Oregon, South Carolina, Texas, Utah, and Washington, plus the District of Columbia. These include both no-fault states and "add-on" states that require PIP to be offered, but do not restrict the right to sue in tort.

[7] Florida, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, New York, North Dakota, and Utah. Pennsylvania and New Jersey are excluded.

[8] "Territory" factors would include where the vehicle is kept and driven, road conditions, the number of accidents in the particular area, etc. Insurers may also offer discounts for safety equipment, for drivers with records free of accidents and violations and for drivers who complete driver education courses.

[9] This data was based on rates in effect on January 1, 2006, based on three hypothetical drivers with a PIP deductible of $250.

Average Annual PIP Premiums in 2006 for Nine Major Insurers[10]

	Tallahassee			Orlando			Miami		
Company	**Driver A**	**Driver B**	**Driver C**	**Driver A**	**Driver B**	**Driver C**	**Driver A**	**Driver B**	**Driver C**
Allstate	$125	$88	$136	$212	$143	$233	$350	$230	$387
Direct General	$268	$262	$451	$359	$351	$608	$960	$938	$1,649
Gov't. Employees	$98	$33	$123	$145	$124	$47	$269	$397	$236
Liberty Mutual	$101	$98	$179	$160	$153	$304	$227	$217	$448
Mercury Ins.	$94	$84	$274	$128	$112	$380	$186	$162	$566
Nationwide Mutual.	$108	$90	$345	$159	$128	$558	$176	$141	$628
Progressive	$73	$84	$182	$134	$155	$347	$233	$272	$618
State Farm	$105	$94	$281	$183	$162	$515	$316	$279	$882
United Auto	$303	$289	$778	$311	$298	$801	$499	$476	$1,320

Driver A is a 40 year-old married female whose care is not operated by a youthful driver. She has one moving violation for speeding less than 15 miles per hour over the speed limit within the past 18 months. She drives a 3-year old sport utility vehicle valued at $25,000. She drives 15,000 miles annually for work and pleasure. Her drive to work is less than 15 miles one-way.

Driver B is a 71 year-old married male. He has had one moving violation for failing to obey a stop sign within the past 18 months. He drives an 8-year old car valued at $10,000. He drives 10,000 miles annually for pleasure.

Driver C is a single 18 year-old male driver who lives with his family. He has had no accidents or moving violations during his two-year driving history. He drives a 5 year-old car valued at $15,000. He drives 12,000 miles annually for school, work, and pleasure to work is less than 15 miles one-way.

PIP Health Care Fraud and Abuse

High costs for health care services drive up PIP insurance costs. Health care fraud and abuse are at an all time high and are the leading cost "drivers" of motor vehicle insurance fraud according to the Director of Insurance Fraud (DIF or division) with the Department of Financial Services. Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes

[10] The insurers are: Allstate Property and Casualty Ins. Co.; Direct General Ins. Co.; Government Employees Ins. Co.; Liberty Mutual Ins. Co.; Mercury Ins. Co. of Florida; Nationwide Mutual Fire Ins. Co.; Progressive American; State Farm Mutual Automobile Insurance Co.; and United Automobile Ins. Co.

that involve heath care clinic fraud,[11] filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies at exorbitant fees for medically unnecessary or non-existent treatments, and patient-brokering (referring patients to medical providers for a bounty), according to representatives with the division. The high cost of health care is driven by increases in per service fees and overutilization of medical services, according to state division officials.

The latest statistics for the DIF indicate that the total number of PIP fraud referrals for 2005-06 were 3,159; this represents an increase of 430 percent over referrals from 1996-97.[12] For 2005-06, the number of criminal investigations opened was 329, the number of arrests made was 307, and 225 cases resulted in convictions. PIP arrests account for approximately 40 percent of all insurance fraud arrests made by the Division.

Florida Auto Injury Insurance Claim Study

In February 2007, the Insurance Research Council[13] released its report entitled, *Florida Auto Injury Insurance Claim Environment*, which was based on a sample of 4,162 auto injury insurance claims from Florida that closed with payment in 2005.[14] The report included the following findings:

- The average total claimed PIP economic loss, consisting primarily of medical expenses, increased 18 percent in three years, from $8,289 in 2002 to $9,769 in 2005. The general rate of inflation based on the Consumer Price Index (CPI) increased 9 percent during this same period and medical care inflation increased 13 percent during this time.
- The average total PIP claim payment also increased significantly faster than the CPI. From 2002 to 2005, the average total PIP payment increased 24 percent to $5,712, compared with $4,606.
- Chiropractors were the most common medical provider submitting charges for treatment of PIP claimants. The percentage of PIP claims with chiropractor charges reached 44 percent, an increase from 33 percent in 2002. In addition, the average total amount charged by chiropractors increased 35 percent over three years, from $4,837 in 2002 to $6,510 in 2005.
- An increased percentage of PIP claimants hired attorneys. More than four in ten PIP claimants (45 percent) hired attorneys in 2005, compared with 34 percent in 2002. The percentage of PIP claimants who qualified for a tort claim steadily increased from 1997 to 2005. In 2005, half (50 percent) of PIP claimants qualified for a Bodily Injury (BI) tort recovery under Florida's no-fault regulation, compared with 42 percent in 2002 and 34 percent in 1997.
- The proportion of PIP claimants who had an MRI (magnetic resonance imaging) rose from 26 percent of all PIP claimants in 2002, to 33 percent in 2005. Another key cost driver is the rapid growth in the cost of computerized tomography (CT) services. The

[11] A health care clinic means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider (s. 400.9905(4), F.S.).
[12] February 2007.
[13] The Insurance Research Council is a division of the American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America.
[14] Earlier Florida claim data were collected as part of national IRC studies in 2002 an 1997.

average total CT charge for PIP claimants increased 31 percent, from $2,755 in 2002, to $3,601 in 2005.

Limited Number of PIP Procedures under a Fee Schedule

Health care providers are not required by law to adhere to a fee schedule or utilization protocols for PIP in Florida except for a limited number of specified diagnostic procedures. For all other procedures, medical health providers may be compensated for "medically necessary" services and may charge "a reasonable amount…for the services and supplies rendered."[15] Charges in excess of the amount customarily charged are prohibited. In determining whether a charge is reasonable "consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute" along with "reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages" and "other information relevant to the reasonableness of the reimbursement of the service, treatment or supply."

Determining what are medically necessary treatments and the amount of reasonable charges is often litigated in Florida courts between providers and insures which further increases costs to the no-fault system. In contrast, fee schedules are used in Florida to limit health care costs for workers' compensation, Medicare, and Medicaid, and contractual fee limits are common between health insurers and providers.

Due to rapidly rising costs for diagnostic tests in Florida, the Legislature enacted several exceptions that make certain diagnostic tests under PIP subject to the worker's compensation medical fee schedule under s. 440.13, F.S. [16] Also, nerve conduction testing (if medically necessary), cannot exceed 200 percent of the Medicare Part B fee schedule for the area where treatment was rendered.[17] Magnetic resonance imaging (MRI) tests cannot exceed 175 percent of the Medicare Part B fee schedule, unless offered at facilities accredited by specified organizations, in which case 200 percent of the Medicare Part B fee schedule may be charged.[18]

Medicare Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare Part A (hospital insurance) covers medically necessary inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care).

[15] Section 627.736(5), F.S.

[16] Section 627.736(5)(b)2., F.S, provides that the diagnostic tests subject to the worker's compensation fee schedule are cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, and surface electromyography.

[17] Section 627.736(5)(b)3., F.S. The Medicare Part B fee schedule for 2001 is used, as adjusted yearly to reflect changes in the Consumer Price Index for All Urban Consumers in the South Region as determined by the U.S. Bureau of Labor Statistics in the Department of Labor.

[18] Id.

It also covers hospice care and some home health care.[19] Medicare Part B (medical insurance) covers medically necessary doctors' services and outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment. Part B also covers outpatient mental health care, outpatient occupational and physical therapy, home health care, and various preventive medical screenings.[20]

Medicare Parts A and B do not cover the following procedures:[21] acupuncture; chiropractic services;[22] cosmetic surgery; custodial care; deductibles, coinsurance or copayments when obtaining certain health care services; dental care and dentures; diabetic supplies; routine eye care or foot care exams; hearing aids and exams; hearing tests; laboratory tests (screening); long-term care; orthopedic shoes; routine or yearly physical exams; prescription drugs; preventive vaccinations; screening tests; or travel.[23] Under Medicare Part C, private insurers approved by Medicare provide for this coverage. Medicare Part D offers prescription drug coverage for everyone with Medicare.

Medicare is subject to a fee schedule under federal law which is a comprehensive listing of fee maximums that are used to reimburse physicians and other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies. Each year the CMS revises the fee schedules and covered benefits under Medicare.

In general, the Medicare fee schedule classifies different patient conditions and illnesses into diagnosis related groups (DRG) and reimbursement amounts vary depending on the region of the country where treatment is rendered.[24] Reimbursement under Medicare Part A uses the Prospective Payment System (PPS), which is based on weighted costs of treating different illnesses and conditions. The PPS uses DRGs to classify patients predicated on the patient's principal diagnosis that is the main reason the patient was admitted into the hospital. Other factors used to determine the DRG include the patient's age, sex, secondary diagnoses, and whether the patient is assigned a surgical or medical DRG. Also factored are the principal procedures performed and the patient's discharge status. Complications (conditions arising during the admission) and comorbidities (preexisting conditions) that each increase the length of a hospital stay by at least one day are also factored in.

Each Medicare patient that is discharged is only assigned one DRG, regardless of the number of services provided or the length on that person's inpatient stay. However, the DRG is assigned a weight factor that takes into account the resources a hospital uses in furnishing care within a

[19] Beneficiaries must meet certain conditions to get these benefits. Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.
[20] See, Centers for Medicare & Medicaid Services, *Medicare & You, 2007*, the official government handbook on Medicare, which can be found online at http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Most people pay a monthly premium for coverage under Part B.
[21] There are some exceptions to this list. See, *Medicare & You, 2007,* page 21, noted under footnote 16.
[22] Except to correct a subluxation (when one or more of the bones of the spine moves out of position) using manipulation of the spine.
[23] Travel relates to health care a person receives traveling outside of the U.S.
[24] Florida Hospital Association, *Medicare 101: An Overview of Medicare Payment Systems* (2005), pg. 1.

certain DRG, when compared to the average patient. Beginning in fiscal year 2007, the CMS is transitioning to cost-based weights rather than basing the rates on hospital charges.

Florida's Workers' Compensation Reimbursement Provisions

The three-member panel ("panel"), consisting of the Chief Financial Officer, or designee, and two members appointed by the Governor, is charged with the responsibility for determining statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians and hospitals.[25] The panel must annually adopt reimbursement schedules for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers (ASC), work hardening programs, pain programs and durable medical equipment. The panel considers the level of payment by other programs, the impact on cost to employers and the impact of reimbursement allowances on health care providers. It authorizes three reimbursement manuals (one for individual health care providers, one for ambulatory surgical centers and one for hospitals). Any provider and insurer may enter into a contract or a managed care agreement setting another reimbursement level.[26] An individual physician, hospital, ASC, work hardening program or pain program must be reimbursed based on either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

Specifically, maximum reimbursement allowances (MRAs) for physician services are statutorily tied to Medicare, with physicians reimbursed at 140 percent of Medicare for surgical procedures and at 110 percent of Medicare for most other services.[27] Approximately 600 physician services not covered by Medicare, but covered by workers' compensation, are reimbursed at the 2003 MRA amount. For services not covered by MRAs, the physician's fee is negotiated based on documentation submitted to the insurer containing information on medical necessity clinical data, charges, fees, relative values, reimbursement and costs for similar procedures. However, the insurer and physician may negotiate fees above or below the fee schedule.

As to reimbursement for prescription medications, the statutory formula sets reimbursement at the average wholesale price, plus a $4.18 dispensing fee.

For hospitals, the insurer applies the Florida Workers' Compensation Hospital Reimbursement Manual to adjust and pay the bill. The manual sets reimbursement according to several criteria, which generally allow the following: inpatient services are set at a per diem allowance unless the total charge exceeds the stop loss point of $50,000, then reimbursement is 75 percent of the usual and customary charge; outpatient scheduled surgery services are set at 60 percent of the usual and customary charge, and, for most other outpatient services, reimbursement is 75 percent of

[25] Section 440.13(12), F.S. The term 'physicians' encompasses health care providers.
[26] When issuing a bill for services, the health care provider uses one of four billing forms: the DWC-9 (individual providers and ambulatory surgical centers); the DWC-10 (pharmacists and medical supply providers); the DWC-11 (dentists); and the DWC-90 (hospitals). The insurer is required to pay or deny a claim within 45 days of receipt.
[27] *Id.* Physicians bill under the Current Procedural Terminology (CPT) code and Healthcare Common Procedure Coding System (HCPCS) including their usual and customary charge. The insurer applies the appropriate reimbursement manual to adjust and pay the bill according to applicable policy limitations and exceptions.

the usual and customary charge. There are exceptions for outpatient non-emergency radiology and clinical laboratory, occupational therapy, physical therapy and speech therapy.[28]

Ambulatory surgical centers (ASC) bill under the appropriate CPT and HCPCS codes including their usual and customary charge from the facility's charge master.[29] The insurer applies the Surgical Centers Reimbursement Manual to adjust and pay the bill according to the maximum reimbursement allowances in the manual. For services not covered by MRAs, reimbursement is set at 70 percent of the ASC's usual and customary charge.

Medical supplier's bill under the HCPCS codes and the insurer applies the Provider Reimbursement Manual to adjust and pay the bill. In general, skilled nursing, home health, emergency transportation and durable medical equipment reimbursement are negotiated based on usual and customary charges. Rental items are paid at the rental price until the purchase price is exceeded and then it converts to the purchase price with a negotiated markup.

Section 440.134, F.S., provides that a self-insured employer or an insurer may furnish medical services through a managed care arrangement under the Workers' Compensation law.

Fee Schedules in Other No-Fault States

Since medical treatment is the primary cost driver for PIP coverage, some states have enacted PIP medical fee schedules in an attempt to contain such costs. New York provides that charges for health services under its PIP law cannot exceed those contained in the state's worker's compensation fee schedule.[30] For treatments that are not included in the worker's compensation fee schedule, the state superintendent of insurance, chairman of the worker's compensation fee schedule board, and the commissioner of health are authorized to establish by rule and regulation fee schedules for such treatments.[31] New Jersey also has a PIP fee schedule, but limits fees to the 75th percentile of the practitioners within the region.[32] New Jersey authorizes the commissioner of insurance to contract with a proprietary purveyor of fee schedules for the maintenance of the fee schedule, which must be adjusted biennially for inflation and to add new medical procedures. Oregon also has a fee schedule for PIP benefits that is tied to its worker's compensation fee schedule.[33]

New Jersey also has adopted treatment protocols for treatment rendered under PIP coverage.[34] The utilization protocols must be recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those

[28] These services are reimbursed based on CPT code (entered by the hospital on its bill) listed in the Health Care Provider Reimbursement Manual (HCPRM) and the insurer makes payment based on the maximum reimbursement allowance. The Hospital Reimbursement Manual incorporates the HCPRM for purposes of clinical lab, x-ray, occupational therapy, physical therapy and speech therapy.
[29] The 'charge master' means for hospitals a comprehensive listing of all the goods and services for which the facility maintains a separate charge.
[30] N.Y. Ins. Law s. 5108(a).
[31] N.Y. Ins. Law s. 5108(b).
[32] N.J. Rev. Stat. 39:6A-4.6 (2004). New Jersey divides itself into three regions for the purpose of setting its fee schedules. See *New Jersey Automobile Fee Schedule*. http://www.state.nj.us/dobi/aicrapg.htm
[33] Or. Rev. Stat. s. 742.525 (2004).
[34] N.J. Rev. Stat. 39:6A-3.1a and 39:6A-fa.

designated or approved by the commissioner of insurance in consultation with the applicable licensing boards in the New Jersey Division of Consumer Affairs.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.736, F.S., pertaining to required personal injury protection benefits. The bill provides that an insurer may apply a maximum limit on charges which is equal to 200 percent of the reimbursement allowed for the applicable procedure code as set forth in the Medicare Part A or Medicare Part B participating fee schedule in effect at the time for the region where the treatment, care, procedure, or service is provided. However, if such treatment, care, procedure, or service is not reimbursable under the Medicare fee schedules, insurers may apply a maximum limitation that is equal to the maximum reimbursesable allowance under workers' compensation, as determined under s. 440.13, F.S., and rules adopted thereunder,[35] which are in effect at the time for the region where the treatment, care, procedure, or service is provided.

If the treatment is not reimbursable under either Medicare or workers' compensation, it is not reimbursable by the insurer. However, this does not allow the insurer to apply any limit on the number of treatments or other utilization limits that apply under Medicare or workers' compensation.

If a PIP insurer limits payments to the referenced fee schedules, the bill prohibits a provider from billing or attempting to collect from an insured any amount in excess of the fee schedule payment limit, other than amounts not covered by the insured's PIP coverage due to deductibles, coinsurance amounts, or maximum policy limits.

The bill removes current provisions that make specific diagnostic tests (i.e., cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, and surface electromyography) subject to the worker's compensation medical fee schedule under s. 440.13, F.S. [36] Also, nerve conduction testing, if medically necessary and done in conjunction with a needle electromyography procedure, cannot exceed 200 percent of the Medicare Part B fee schedule for the area where treatment was rendered.[37] Magnetic resonance imaging (MRI) tests cannot exceed 175 percent of the Medicare Part B fee schedule, unless offered at facilities accredited by specified organizations, in which case 200 percent of the Medicare Part B fee schedule may be charged.[38]

Section 2. Provides that effective January 1, 2009, sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S., constituting the Florida Motor Vehicle No-Fault law, are repealed unless reviewed and reenacted by the Legislature before that date.

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[35] See, rule 69L-7.602, F.A.C.
[36] Section 627.736(5)(b)2., F.S.
[37] Section 627.736(5)(b)3., F.S. The Medicare Part B fee schedule for 2001 is used, as adjusted yearly to reflect changes in the Consumer Price Index for All Urban Consumers in the South Region as determined by the U.S. Bureau of Labor Statistics in the Department of Labor.
[38] Id.

Section 3. Provides that Section 19 of chapter 2003-411, F.S., is repealed, and sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S., are reenacted and shall not stand repealed on October 1, 2007, as provided for in that section.

Section 4. Provides that the bill will take effect July 1, 2007, and shall apply to treatment, care, procedures or service rendered or performed on or after that date.

Motor vehicle insurers contend that disputes over what are reasonable charges is often litigated in Florida courts between providers and insurers which further increases costs to the no-fault system. Insurers argue that fee schedules are already used in Florida to limited health care costs for worker's compensation, Medicare, Medicaid and contractual fee limits are common between health care providers and insurers. If fee schedules are imposed, health care costs will be reduced and litigation will be curbed since disputes over the amount of charges would be eliminated. Insurers also contend that fraud is likely to be reduced if a fee schedule is enacted because it would prevent highly inflated charges for bogus treatments since the incentive to overcharge would be eliminated.

Many medical providers oppose medical fee schedules. Such measures operate as governmental price controls and are contrary to the values of the free market. Opponents claim that some physicians may choose not to accept PIP claimants and that problems of access to quality care will develop that are similar to those asserted to exist in the Medicaid, Medicare and worker's compensation system in Florida.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PIP policyholders may benefit because PIP premiums could be reduced as a result of lower payments for PIP medical services due to application of a PIP fee schedule.

Insurers utilizing the fee schedule would benefit due to the payment of lower amounts and because litigation should be reduced regarding whether charges for medical care are "reasonable." This may also help reduce fraudulent PIP claims by reducing the financial incentive for such claims.

Medical providers treating persons injured under PIP may receive lower payments for such services if the insurer applies the allowable fee schedules. Some physicians may choose not to accept PIP claimants due to these fee limitations. According to a 2005 report published by the American Hospital Association, Medicare payments (100 percent of Medicare) to hospitals nationwide in 2003 equaled about 95 percent of the hospitals' cost of care.[39] Under the bill, PIP insurers could apply a limit of 200 percent of Medicare.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[39] *The Fragile State of Hospital Finances,* American Hospital Association (March, 2005), available at: http://www.aha.org/aha/content/2005/pdf/FragileStateChartPack.pdf

VIII. Summary of Amendments:

None.