HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 13C Motor Vehicle Insurance
SPONSOR(S): Bogdanoff
TIED BILLS: HB 15C **IDEN./SIM. BILLS:** SB 40C

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Insurance	11 Y, 1 N	Overton	Overton
2) Jobs & Entrepreneurship Council	10 Y, 3 N	Overton	Thorn
3)			
4)			
5)			

SUMMARY ANALYSIS

In 2003, the Legislature repealed the Florida Motor Vehicle No-Fault law and provided that the repeal would take effect October 1, 2007, unless the provisions were reenacted by the Legislature. The Legislature did not reenact the No-Fault Law, so the law is no longer in effect.

This bill reenacts the No-Fault Law as it existed on September 31, 2007 for policies issued on or after the date the bill becomes law. Additionally, the bill reenacts and revises the No-Fault law for polices issued on or after January 15, 2008 and provides procedures for the transition.

Under the Florida Motor Vehicle No-Fault law motor vehicle owners had to maintain $10,000 worth of first-party insurance known as Personal Injury Protection, which is commonly referred to as PIP. For polices issued on or after January 15, 2008, the PIP requirement is revised.

- PIP will continue to cover 80% of medical expenses up to $10,000, but the benefits are limited to services and care provided, ordered, or prescribed by a physician, osteopath, or dentist or provided by other specified health care providers.
- Insurers may limit PIP reimbursement to 80% of a schedule of maximum charges based on usual and customary charges, or the Medicare or the workers' compensation fee schedule, depending on both the service and the entity providing the service.
- The PIP insurer must reserve $5,000 of PIP benefits for payment to physicians rendering emergency care or inpatient care in the hospital.

The use of a contingency risk multiplier in the calculation of attorney's fees due under the No Fault law is prohibited and the amount of attorney's fees due under the No Fault law is restricted to the greater of $10,000 or three times the amount of benefits secured by the attorney for claims based on polices issued on or after January 15, 2008.

The Attorney General and the Office of Insurance Regulation are given additional authority to investigate and initiate actions against an insurer that fails to pay valid PIP claims with such frequency as to indicate a general business.

The bill clarifies that property damage liability insurance is mandatory and the requirement remains effective during any period that PIP is not required.

Except as provided, the bill takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility - The bill requires that motor vehicle owners maintain first-party security for medical care and services rendered as a result of a motor vehicle accident.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Florida Motor Vehicle No-Fault Law

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] The Legislature did not reenact the law and it is currently repealed.

Personal Injury Protection (PIP)

Under Florida's Motor Vehicle No-Fault Law, motor vehicle owners were required to maintain $10,000 worth of first-party insurance known as Personal Injury Protection, which is commonly referred to as PIP. PIP coverage provides up to $10,000 per person for loss sustained as a result of bodily injury, sickness, disease, or death that arises from owning, maintaining, or using an insured motor vehicle. PIP benefits are available for certain express damages sustained in a motor vehicle accident, regardless of fault.

In exchange for the automatic $10,000 PIP benefit, the insured motor vehicle owner may not sue for damages covered by PIP. Additionally, the motor vehicle owner is immune from liability for damages covered by PIP. Nonetheless, special (economic) damages such as medical expenses in excess of the PIP benefit may be recovered in tort, as may a limited class of general (non-economic) damages for extreme forms of pain and suffering.[3]

PIP coverage extends to the named insured, relatives who reside in the same household, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and other persons struck by the insured motor vehicle who suffer bodily injury and are not occupants of a self-propelled vehicle at the time that they suffer the injury.[4] Required PIP benefits are detailed in section 627.736(1), Florida Statutes. They include the following: 80% of medically necessary expenses, 60% of lost wages, 100% of replacement services (household-type services that the injured party would provide in the absence of the injury), and a $5,000 death benefit.

Since the No-Fault law has been repealed, motor vehicle owners are no longer required to have PIP and are no longer covered by the immunity provision that protects the insured from tort actions by others for pain, suffering, mental anguish, and inconvenience arising out of the vehicle accident.

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[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] Under section 627.737(2), a person may sue in tort for pain and suffering as a result of a motor vehicle accident only if there is: (a) significant and permanent loss of an important bodily function; (b) permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement; (c) significant and permanent scarring or disfigurement; or (d) death. This is referred to as "piercing the verbal threshold."

[4] Section 627.736(1), F.S.

PIP Fraud

Over time, PIP has been subject to a variety of fraudulent activities. Examples of PIP fraud include: solicitation of individuals to participate in fraud; staging motor vehicle accidents; billing for treatment that never occurred; and overbilling/build-up of legitimate claims. In 2000, the Fifteenth Statewide Grand Jury issued a report on PIP Fraud, which concluded that PIP is beset with fraud. It made a number of recommendations for addressing fraud, many of which were adopted by the Legislature in 2001 and 2003.

In 2001, legislation was enacted that did the following: provided a medical fee schedule for certain diagnostic procedures; provided additional funding for anti-fraud measures; provided additional funding for assistant state attorneys and fraud investigators; prohibited payment to brokers; required the Agency for Health Care Administration (AHCA) to license medical clinics; and increased fraud penalties.[5]

In 2003, legislation was enacted that did the following: increased restrictions on access to medical reports; increased health care clinic regulation; provided that insurers do not have to pay PIP benefits if the insured has committed PIP fraud; required the Department of Health (DOH) to create a list of diagnostic tests that are not deemed to be medically necessary, and provided that insurers do not have to pay for invalid diagnostic tests; prohibited unlawful solicitation of business within 60 days after a motor vehicle accident; prohibited lawyers and licensed health care providers from ever soliciting business; gave a felony designation to certain PIP fraud crimes (solicitation with intent to defraud, using confidential information from police reports, unlawfully obtaining/using confidential accident reports, operating unlicensed clinics, filing false insurance application or creating false insurance record, and organizing, planning, or participating in an intentional motor vehicle collision).[6] Additionally, the legislation provided for the Florida Motor Vehicle No-Fault Law to sunset on October 1, 2007.

The Division of Insurance Fraud (DIF) has continued to handle an increasing number of fraud cases. From 2002 to 2005, PIP fraud referrals have increased 300%, from 615 referrals to 2,628 referrals; between 2002 and 2005, PIP fraud referrals made up 15% of all referrals to the Division of Insurance Fraud.[7] There were 225 convictions for PIP fraud during the fiscal year 2005-2006, which made up 36% of the 620 total insurance fraud convictions for that year.[8] Of those 225 convictions, 124 were for staged motor vehicle accidents.

Effect of the Bill

Reenacting the Motor Vehicle No-Fault Law

The bill reenacts the Florida Motor Vehicle No-Fault Law effective upon the bill becoming a law for polices effective on or after October 1, 2007, but before January 15, 2008. The changes to the PIP benefit are effective on January 15, 2008. The bill is intended to be remedial and curative in nature and to minimize confusion concerning the changes made to ss. 627.730-627.7405, Florida Statutes. Therefore, the Florida Motor Vehicle No-Fault Law shall continue to be codified in the same sections of the Florida Statutes.

Property Damage Liability Coverage

The repeal of the No-Fault law has caused uncertainly as to whether the mandatory requirement for property damage liability insurance of at least $10,000 is still in effect, and what authority, if any, the Department of Highway Safety and Motor Vehicles (DHSMV) has to enforce the requirement. A recent

[5] Ch. 2001-271, Laws of Florida.
[6] Ch. 2003-411, Laws, of Florida.
[7] Report of Senate Committee on Banking and Insurance, Report No. 2006-102, dated Nov. 2005.
[8] Florida Department of Financial Services, 2006 Stat Pack, recorded on July 21, 2006.

legal opinion from DHSMV concluded that the repeal of No-Fault does not affect the requirement for maintaining property damage (PD) liability coverage.[9] However, the requirement that motor vehicle policies must also provide coverage for property damage liability is found in s. 627.7275(1), F.S., which is part of the No-Fault law which sunsetted. Additionally, some enforcement provisions refer only to the PIP mandate.

Effective upon the bill becoming a law, the bill clarifies that property damage liability insurance is mandatory and remains effective during any period that PIP is not required.

Additionally, the bill:

- Amends s. 316.646, F.S., to require persons to have proof of PD liability coverage (insurance card) in their immediate possession while operating a motor vehicle (as currently required for PIP).

- Amends s. 320.02, F.S., to specify that proof of PD liability presented at registration is not a warranty of its accuracy and that neither the DHSMV or any tax collector is liable for any insufficiency or falsification (as currently provided for PIP).

- Amends s. 321.245, F.S., relating to use of certain funds in the Highway Safety Operating Trust Fund, to correct a cross-reference to provisions that are transferred by the bill.

- Amends s. 324.022, F.S., to clarify that $10,000 of PD liability coverage is mandatory for specified motor vehicles.

- Creates s. 324.0221, F.S., to enforce mandatory PD liability and PIP, as required for PIP in ss. 627.733(6)-(7) and 627.736(9), F.S. (repealed on October 1, 2007). This section requires insurers to report to DHSMV policy cancellations, non-renewals, and new policies written, and requires DHSMV to suspend the driver's license of persons who do not obtain the required coverage. A person whose license is suspended is subject to a $150 driver's license reinstatement fee, $250 for a second reinstatement, and $500 for each subsequent reinstatement within a 3-year period. These are the same requirements for enforcing PIP/PD that were subject to repeal on October 1 2007, except that the public records exemption for the reports by insurers is deleted.[10]

- Amends. 627.7275, F.S., related to motor vehicle liability policies, to make technical conforming changes. This section maintains the requirement that a policy providing PIP coverage must also include PD liability coverage.

- Amends s. 627.7295, F.S., which currently requires a policy that provides both PIP and PD liability to be non-cancellable for a 60-day period and to require a minimum two months down payment of the premium, with exceptions. The bill specifies that this requirement applies to a policy providing PIP, PD liability, or both. (This section is not subject to repeal.)

Limitation on Providers

The PIP medical benefit in effect prior to October 1, 2007, paid for 80% of all reasonable expenses for medically necessary medical, surgical, x-ray, dental, and rehabilitative services.[11] There was no limitation on who provided, ordered, or prescribed the services.

[9] See Memos dated 8/21/07 and 8/24/07 from Michael J. Alderman, Senior Assistant General Counsel, DHSMV, to Electra Theodorides-Bustle, Executive Director, DHSMV, regarding Enforcement of Motor Vehicle Property Liability Insurance Requirement of Section 324.022, Florida Statutes, etc. on file with the House Committee on Insurance

[10] HB 15C would create a new public records exemption for this information.

[11] Section 627.736(1)(a), F.S.

The bill provides that for policies effective or renewed on or after January 15, 2008, PIP will continue to pay 80% of medical expenses up to $10,000, but reimbursement is limited to the following medical services and care:

- Services and care that are *provided, lawfully supervised, ordered, or prescribed by*:
  - A physician licensed under chapter 458.
  - An osteopath licensed under chapter 459.
  - A dentist licensed under chapter 466.

- Services and care that are *provided by*:
  - A chiropractic physician licensed under chapter 460.
  - A hospital or ambulatory surgical center licensed under chapter 395.
  - Emergency transportation and treatment by a person or entity licensed under ss. 401.2101-401.45.
  - An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466, or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.
  - An entity wholly owned, directly or indirectly, by a hospital or hospitals.

- Services and care that are *provided by*:
  - A health care clinic licensed pursuant to ss. 400.990-400.995 which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.

- Services and care that are *provided by* a health care clinic licensed pursuant to ss. 400.990-400.995, but not accredited by one of the organizations above, that meets all of the following:
  - Has a medical director that is a Florida licensed physician, osteopath, or chiropractor;
  - Has either been continuously licensed for more than three years or is a publicly traded corporation; and
  - Provides at least four of the following medical specialties: 1) general medicine; 2) radiography; 3) orthopedic medicine; 4) physical medicine; 5) physical therapy; 6) physical rehabilitation; 7) prescribing or dispensing outpatient prescription medication; 8) laboratory services.

- Magnetic resonance imaging services if such services have been lawfully ordered by a licensed health care practitioner.

Current law does not limit the types of providers that can order or provide reimbursable services under PIP. Specifically delineating and limiting the types of providers may give insurers more control over what they pay for and may reduce the likelihood of fraud.

Health Care Clinics

Part XIII of ch. 400, F.S., contains the Health Care Clinic Act (Act) (ss. 400.990-400.995, F.S.). The Act was passed in 2003 to reduce fraud and abuse occurring in the PIP insurance system. Under the Act, the Agency for Health Care Administration (AHCA or agency) licenses health care clinics, ensures that such clinics meet basic standards, and provides administrative oversight. Any entity that meets the definition of a "clinic" (an entity at which health care services are provided to individuals and charges for reimbursement for such services) must be licensed as a clinic.[12] Every entity that meets the definition of a "clinic" must maintain a valid license with the AHCA at all times, and each clinic location must be

[12] Section 400.9905(4), F.S.

licensed separately. Each clinic must file in its application for licensure information regarding the identity of the owners, medical providers employed, and the medical director and proof that the clinic is in compliance with applicable rules. The clinic must also present proof of financial ability to operate a clinic. A level 2 background screening pursuant to ch. 435, F.S., is required of each applicant for clinic licensure. A license may not be granted to a clinic if the applicant has been found guilty of, regardless of adjudication, or has entered a plea of *nolo contendere* or guilty to, any offense prohibited under the level 2 standards for screening or a violation of insurance fraud under s. 817.234, F.S., within the past 5 years.

Each clinic must have a medical director or clinic director who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for various activities on behalf of the clinic, including:

- Conducting systematic reviews of clinic billings to ensure billings are not fraudulent or unlawful. If an unlawful charge is discovered, immediate corrective action must be taken;

- Allowing full and complete access to the premises and to billing records. (Licensed clinics are subject to unannounced inspections of the clinic by AHCA personnel to determine compliance with the Health Care Clinic Act and applicable rules. The agency may deny, revoke, or suspend a health care clinic license and impose administrative fines of up to $5,000 per violation pursuant to s. 400.995, F.S.); and

- Although all clinics must be licensed with the AHCA, s. 400.9905(4), F.S., contains a lengthy list of entities that are not considered a “clinic” for the purposes of clinic licensure.

Health care providers and practitioners may voluntarily apply to the AHCA for a certificate of exemption under the act, but are not required to do so. Such providers find it useful to obtain a certificate of exemption to present to an insurance company, particularly a PIP insurer, to prove that the provider is not required to be licensed as a health care clinic.

According to the Division of Insurance Fraud (DIF) officials, the magnitude of the PIP fraud problem is illustrated by the large number of health care clinics established in Florida under the Health Care Clinic Act (Act). Current figures indicate that over 65 percent[13] of the more than 2,435 medical clinics licensed by the AHCA statewide are located in Dade, Broward, and Palm Beach counties. Moreover, 4,590 clinics have received exemption certificates and are therefore subject to no state regulation. (This figure does not count the clinics that have decided not to file for an exemption certificate with the AHCA.) Division intelligence indicates that “hundreds” of these clinics have been established primarily in the South Florida area for the sole purpose of perpetrating PIP fraud according to DIF officials.[14]

Clinics are often not owned by a licensed medical professional and may be a higher fraud risk than other health care providers because their owners do not risk their ability to continue a medical profession. However, health care clinic licensure standards are minimal compared to other licensure programs, and focus on financial solvency, criminal background checks, and fraudulent billing rather than quality of care. In addition, unlike physician licensure, it is possible for one person or company to hold multiple clinic licenses and operate multiple clinics, and to more successfully seek a new license after discontinuing a prior license.

The bill imposes additional qualifications on health care clinics in order to receive PIP reimbursement, requiring health care clinics to either obtain accreditation by certain national accrediting organizations or meet additional criteria that lower the risk of fraud. The four accrediting organizations listed in the bill – the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation

[13] National Insurance Crime Bureau, White Paper: Addressing Personal Injury Protection Fraud through the Florida Medical Fraud Task Force (August 2005).
[14] Division of Fraud Budget Request, FY 2005-2006.

Association for Ambulatory Health Care, Inc. - are all national organizations that accredit health care clinics. These accreditation organizations use rigorous processes in evaluating a provider's internal business practices, outcomes management and performance improvement, quality of services provided, and continuity of care to ensure high-quality care focused on the needs of the patients. Factors considered in the accreditation process include, but are not limited to, whether a provider has: retained adequate, competent medical personnel to provide services; acquired adequate space for providing necessary services; established a system of accountability that measures the success of its services by evaluating the outcomes achieved by its patients; established adequate procedures for managing health information internally and externally and obtaining informed consent; established a method for improving organizational performance; addressed ethical issues in providing patient care; developed procedures to ensure patient privacy; developed and implemented a safety and security plan and provides a safe environment for the patient, including the detection, prevention and control of infection; and developed a human resource plan that ensures adequate staffing and job training; a defined, clear, and active governance structure.

The bill imposes alternative criteria on non-accredited clinics for PIP reimbursement. Current clinic licensure law requires clinics to have a medical director who is a licensed medical doctor, osteopath, chiropractor or podiatrist.[15] The bill requires clinics to have a medical director who is a licensed medical doctor, osteopath or chiropractor to receive PIP reimbursement. In addition, the bill requires the non-accredited clinic to be continuously licensed for more than three years, or be a publicly traded corporation registered with the U.S. Securities and Exchange Commission. The three-year requirement would eliminate clinics that exist for a short period of time, often operated by a person or entity that opens and closes one new clinic after another, which is an indicator of possible fraud patterns.

Publicly traded corporations have enhanced fraud deterrents because they are subject to the federal Sarbanes-Oxley Act of 2002.[16] The Act established that, effective in 2006, all publicly-traded companies are required to submit an annual report of the effectiveness of their internal accounting controls to the Security and Exchange Commission. Provisions of the Sarbanes-Oxley Act detail criminal and civil penalties for noncompliance, certification of internal auditing and increased financial disclosure. All public U.S. companies and non-U.S. companies with a U.S. presence must comply with this law, the essence of which relates to corporate governance and financial disclosure. In addition to lawsuits, a corporate officer who does not comply with this law or submits an inaccurate certification is subject to a fine up to $1 million and ten years in prison, even if done mistakenly. If an incorrect certification was submitted purposely, the fine can be up to $5 million and twenty years in prison.

The bill also provides that the Financial Services Commission adopt by rule the form that must be used by an insurer and health care clinics to document that the health care clinic meets the applicable criteria and the rule must include a requirement for a sworn statement or affidavit.

Fee Schedules

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."[17] 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

[15] Sections 400.9905(5), 400.9935, F.S.
[16] See www.Sarbanes-Oxleycompliance. The Act, sponsored by US Senator Paul Sarbanes and US Representative Michael Oxley, represented one of the biggest changes to federal securities laws in recent history. The enactment of this law came as a result of the large corporate financial scandals involving Enron, WorldCom, Global Crossing and Arthur Anderson.
[17] Section 627.736(5), F.S.

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. [18] 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.[19] 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.[20]

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). It also covers hospice care and some home health care.[21] 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.[22]

Medicare Parts A and B do not cover the following procedures:[23] acupuncture; chiropractic services;[24] 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.[25] Under Medicare Part C, private insurers approved by Medicare provide for this coverage. Medicare Part D offers prescription drug coverage for everyone with Medicare.

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[18] 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.
[19] 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.
[20] Id.
[21] 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.
[22] 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.
[23] There are some exceptions to this list. See, *Medicare & You, 2007*, page 21, noted under footnote 16.
[24] Except to correct a subluxation (when one or more of the bones of the spine moves out of position) using manipulation of the spine.
[25] Travel relates to health care a person receives traveling outside of the U.S.

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.[26]

Florida's Workers' Compensation Reimbursement Provisions

In workers' compensation, 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.[27] 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.[28] 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.[29] 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 the usual and customary charge. There

[26] Florida Hospital Association, *Medicare 101: An Overview of Medicare Payment Systems* (2005), pg. 1.
[27] Section 440.13(12), F.S. The term 'physicians' encompasses health care providers.
[28] 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.
[29] *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.

are exceptions for outpatient non-emergency radiology and clinical laboratory, occupational therapy, physical therapy and speech therapy.[30]

Ambulatory surgical centers (ASC) bill under the appropriate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes including their usual and customary charge from the facility's charge master.[31] 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.

Usual and Customary Charges

The "usual and customary charge" is a standard occasionally used in the health care industry to define third party reimbursement outside the context of a negotiated fee agreement between the payer and the provider. This standard is used in regulating health maintenance organizations (HMOs): Florida law sets the reimbursement amount for emergency services provided by providers that do not have a contract with the HMO at the lesser of the provider's charges or the usual and customary charge for the service, or the charge mutually agreed to within 60 days.[32] Similarly, this standard is used by the Florida Medicaid program: Florida law sets fee-for-service rates at the lesser of the amount billed, the usual and customary charge, or the maximum fee set by the Medicaid program.[33]

The usual and customary charge standard can be based on the individual provider billing habits or on the billing practices of the community of like providers in the relevant geographical area.

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.[34] 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.[35] New Jersey also has a PIP fee schedule, but limits fees to the 75th percentile of the practitioners within the region.[36] New Jersey authorizes the commissioner of insurance to contract with

[30] 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.

[31] The 'charge master' means for hospitals a comprehensive listing of all the goods and services for which the facility maintains a separate charge.

[32] Section 641.513(5), F.S.

[33] Section 409.908(3), F.S.

[34] N.Y. Ins. Law s. 5108(a).

[35] N.Y. Ins. Law s. 5108(b).

[36] 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

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.[37]

New Jersey also has adopted treatment protocols for treatment rendered under PIP coverage.[38] 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 designated or approved by the commissioner of insurance in consultation with the applicable licensing boards in the New Jersey Division of Consumer Affairs.

Medical Fee Limitations in the Bill

For policies effective on or after January 15, 2007, the bill allows PIP insurers to limit reimbursement to 80% of the following schedule of maximum charges:

- Emergency transport and treatment by providers licensed under ch. 401, F.S. (emergency transportation): 200 percent of Medicare.
- Emergency services and care provided by a hospital licensed under ch. 395, F.S.: 75 percent of the hospital's usual and customary charges.
- Emergency services and care rendered by a physician and related inpatient services rendered by a physician: usual and customary charges in the community.
- Hospital inpatient services other than emergency services and care: 200 percent of Medicare Part A applicable to the hospital providing care.
- Hospital outpatient services other than emergency services and care: 200 percent of the Medicare Part A Ambulatory Payment Classification applicable to the hospital providing outpatient services.
- For all other medical services, supplies, and care: 200 percent of the applicable Medicare Part B fee schedule.

If medical care is not reimbursable under Medicare, the insurer may limit reimbursement to 80% of the maximum reimbursement under the workers' compensation fee schedule as determined under s. 440.13, F.S., and rules adopted pursuant to that section.

If services, supplies, or care are not reimbursable under Medicare or workers' compensation the insurer is not required to provide reimbursement.

The applicable fee schedule under Medicare is the fee schedule in effect at the time services, supplies, or care are provided and for the area in which such services are rendered, except that it may not be less than the applicable Medicare part B fee schedule for medical services, supplies, and care subject to Medicare Part B. Thus, as Medicare fee schedules are revised by the Centers for Medicare and Medicaid services, those schedules would be used to calculate PIP reimbursement.

The bill neither authorizes nor prohibits insurers from applying utilization limits, but does clarify that the section of law authorizing the fee schedule does not allow the insurer to apply any utilization limits that apply under Medicare or workers' compensation.

An insurer that applies the PIP fee schedule must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether the provider would be entitled to reimbursement under Medicare due to restrictions on the type of health care provider that may be reimbursed for a particular procedure. Thus, a PIP insurer must provide reimbursement for care and treatment provided by any provider so long as the care is within the provider's practice license and Medicare provides reimbursement for such care or treatment to any type of provider.

[37] Or. Rev. Stat. s. 742.525 (2004).
[38] N.J. Rev. Stat. 39:6A-3.1a and 39:6A-fa.

A medical provider may not balance bill the insured for treatment and services for which they receive reimbursement from an insurer that applies the PIP fee schedule. However, the provider may bill insured for the 20 percent not paid by PIP. Also, once PIP benefits are exhausted, the PIP fee schedule does not apply to treatment and services for which the provider bills the patient or the patient's health insurer.

Priority of Payment for Physicians Rendering Care in a Hospital

Under current law, PIP reimbursements are due from an insurer 30 days after a medical service provider furnishes a written claim to the insurer and overdue payments are entitled to interest.[39] No funds are reserved for any purpose. Most service providers are required to submit their bills not more that 35 days after the service is rendered or the insurer is not required to pay the bill.[40] There is no time limit for submission of bills by hospitals and other providers of emergency services[41]; however, if they do not quickly submit their bills, they risk having benefits exhausted by other claims.

For policies issued on or after January 15, 2008, the bill provides that when the PIP insurer receives notice of an accident, the insurer must reserve $5,000 of PIP benefits for payment to physicians or dentists who provide emergency services and care, as defined in s. 395.002(9)[42], or who provide hospital inpatient care.

Thirty days after the insurer receives notice of an accident, the unclaimed amount of the reserve may be used to pay claims from other providers.

The required time to pay claims to other providers is tolled for the time period the insurer is required to hold such claims due to this requirement. However, there is no tolling of the time period by which an insurer must pay a provider for treatment with regard to the $5,000 of PIP benefits not held in reserve to pay physicians or dentists rendering emergency or inpatient care in a hospital.

Additionally, this provision does not require an insurer to establish a claim reserve for insurance accounting purposes.

Death Benefits

The PIP death benefit in effect prior to October 1, 2007, was $5,000 per person.[43] The bill clarifies that the death benefit is equal to the lesser of $5,000 or the remainder of the unused personal injury protection benefits.

Demand Letter

For polices effect prior to October 1, 2007, the insurer must receive a demand letter prior to the initiation of litigation on the payment of a claim.[44] The demand letter must provide the insurer with name of the insured, the claim or policy number, and detailed information supporting the claim.[45]

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[39] Section 627.736(4), F.S.
[40] Section 627.736(5)(c)1.,F.S.
[41] Id.
[42] "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.
[43] Section 627.736(1)(c), F.S.
[44] Section 627.736(11), F.S.
[45] Section 627.736(11)(b), F.S

If the insurer paid the claim within 15 days of receipt of the demand letter, the insurer was not obligated to pay attorney's fees.[46]

The bill extends the period of time for the insurer to pay the claim from 15 days to 30 days. This extension will give insurers more time to investigate claims before a lawsuit is filed.

Unfair or Deceptive Trade Practices

Under current law, the Office of Insurance Regulation is empowered to investigate insures to determine whether they are engaged in unfair or deceptive trade practices.[47] Insurers who engage in unfair trade practices are subject to fines[48], cease and desist orders[49], and revocation of their authorization to conduct insurance business.[50]

The bill provides that an insurer who fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice is engaging in a prohibited unfair or deceptive practice.

The Office of Insurance Regulation is given the authority within its regulatory jurisdiction to examine and investigate the affairs of insurers in this state in order to determine whether they have been or are engaged in the failure to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice. Insurers who engage in such unfair trade practices will be subject to fines, cease and desist orders, and revocation of their authorization to conduct insurance business.

Florida Deceptive and Unfair Trade Practices Act

The Florida Deceptive and Unfair Trade Practices Act (FDUTPA), part II of ch. 501, F.S., provides remedies and penalties for "[u]nfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce."[51] Willful violations of FDUTPA occur when the person knew or should have known that the conduct was unfair, deceptive, or prohibited by rule.[52] Remedies for acts prohibited by FDUTPA may include an action to enjoin a person from committing such acts,[53] as well as the imposition of a civil penalty of not more than $10,000.[54] A person or entity found liable for a violation of FDUTPA may be assessed a civil penalty, but orders of restitution or reimbursement are given priority over the imposition of a civil penalty.[55]

Actions may be brought by a state attorney, the Department of Legal Affairs,[56] or by a consumer.[57] The Attorney General[58] or other enforcing authority may bring an action on behalf of a consumer or governmental entities for the actual damages caused by an act or practice in violation of FDUTPA.[59]

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[46] Section 627.736(11)(d), F.S.
[47] Section 626.9561, F.S. See Chapter 626, Part IX, on prohibited unfair insurance trade practices.
[48] Section 626.9521(2), F.S.
[49] Section 626.9581, F.S.
[50] Id.
[51] Section 501.204, F.S.
[52] 10 Fla. Jur. 2d *Consumer Etc. Protection* s. 159 (2006).
[53] Section 501.207(1)(b), F.S.
[54] Section 501.2075, F.S. Under s. 501.2077, F.S., the penalty for a violation under FDUTPA involving persons over age 60 or handicapped persons is increased to $15,000 per violation.
[55] 10A Fla. Jur 2d *Consumer Etc. Protection* s. 159 (2006), cites s. 501.2077(3), F.S., for the general proposition that orders of restitution or reimbursement are given priority over the imposition of civil penalties. This section of statute, however, addresses violations involving senior citizens or handicapped persons. It is unclear whether reimbursement of creditors takes priority over payment of civil penalties where the victims are not senior citizens or handicapped persons.
[56] Section 501.203(2), F.S.
[57] Section 501.211(1), F.S.
[58] The Attorney General is the head of the Department of Legal Affairs. See s. 20.11, F.S.
[59] Section 501.207(1)(c), F.S.

The bill authorizes the Department of Legal Affairs (Attorney General) to investigate and initiate actions for insurers who fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, utilizing the powers and duties specified in FDUTPA. [60]

Joinder of Claims

The bill requires that in any civil action brought to recover PIP benefits by a claimant against an insurer, all claims related to the same health care provider for the same injured patient must be brought in a single action, unless good cause can be shown why the claims should be brought separately. If a court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

Attorney's Fees

Under the current No-Fault law, insurers are required to pay attorney's fees under s. 627.428, F.S., if they lose in court to insureds or to beneficiaries under an insurance policy or contract. However, if insurers prevail in court, their fees are not paid by the losing side. This section is known as the "one-way attorney's fee" provision.

Attorney's fees are calculated according to the application of two common law-created provisions: lodestar and contingency risk multipliers.[61] A contingency risk multiplier is a number ranging from 1.0 to 2.5 that may be applied by the court when it awards attorney's fees. It may be applied once the court initially determines the lodestar figure (which is basically the number of hours expended by an attorney on a particular case, multiplied by an hourly rate). The contingency risk multiplier may be applied to the lodestar figure by multiplying the risk multiplier number (ranging from 1.0 to 2.5) times the lodestar figure to determine the attorney's ultimate fee.

The lodestar factors utilized by a court in determining a reasonable attorney's fee are enunciated in the Florida Bar Code of Professional Responsibility under Rule 4-1.5. The eight factors listed include:

- The time and labor required, the novelty, complexity, and difficulty of the questions involved, and the skill requisite to perform the legal service properly.
- The likelihood that the acceptance of the particular employment will preclude other employment by the attorney.
- The fee customarily charged in the locality for legal services of a comparable nature.
- The significance of, or amount involved in, the subject matter of the representation, the responsibility involved in the representation, and the results obtained.
- The time limitations imposed by the client or by the circumstances.
- The nature and length of the professional relationship with the client.
- The experience, reputation, diligence, and ability of the lawyer performing the services.
- Whether the fee is fixed or contingent.

After the lodestar is calculated, the court considers three factors as to whether the risk multiplier is necessary:

1) Whether the relevant market requires a contingency fee multiplier to obtain competent counsel;
2) Whether the attorney was able to mitigate the risk of nonpayment in any way; and,
3) The amount involved in the case, the result obtained, and the type of fee arrangement between the attorney and the client.

[60] An exemption is created to the statutory exclusion in s. 501.212, F.S., that currently exempts entities regulated by the Office of Insurance Regulation from the Florida Unfair and Deceptive Trade Practices Act (ss. 501.201-501.213, F.S.).
[61] See *Standard Guaranty Insurance Co. v. Quanstrom,* 555 So.2d 828, (Fla. 1990).

Other factors are utilized by the court that involve consideration of the chances of success at the outset of trial:

1) If success was more likely than not at the outset, the court may apply a multiplier of 1 to 1.5;
2) If success was approximately even at the outset of trial, the court may apply a multiplier of 1.5 to 2.0;
3) If success was unlikely at the outset, the court may apply a multiplier from 2.0 to 2.5 may be applied.

The bill restricts the amount of attorney's fees due under the No-Fault law to the greater of $10,000 or three times the amount of benefits secured by the attorney. Also, the bill prohibits the application of a contingency risk multiplier in the award of attorney's fees in suits based on claims arising under the No-Fault law.

Electronic Payments

For the PIP benefit in effect prior to October 1, 2007, most were required service providers submit their bills to the insurer within 35 days after the service was rendered, or the insurer was not required to pay the bill.[62] The "postmark" date began the time period for counting the 35 days.

The bill provides that the 35 days begins on the postmark date or the electronic submission date. This will allow providers to more quickly and efficiently submit their bills to the insurance companies.

The bill also provides that any notice, documentation, transmission, or communication of any kind required or authorized under the No-Fault law may be transmitted electronically if all the parties mutually and expressly agree. Any such agreed transmission must be by secure electronic data transfer that is consistent with state and federal privacy and security laws.

Transition

Section 22 of the bill provides for a transition from revived and re-enacted the Florida Motor Vehicle No-Fault Law which apples to policies issued on or after the effective date of the act[63] to the revised PIP benefit for policies issued or renewed on or after January 15, 2008. Thus, the "old" No-Fault Law (Sections 8 through 19 of the bill) will apply to policies issued on or after the date the bill becomes law, requiring that such policies include PIP coverage and be subject to the No-Fault Law as it existed before its repeal. The PIP reforms in Sections 20 and 21 will apply to policies issued or renewed on or after January 15, 2008.

The transition section of the bill states that within 30 days after the act's effective date, insurers issuing coverage that is subject to no-fault requirements must:

- Deliver a revised notice of premium and policy changes that includes PIP benefits to each policyholder whose policy has an effective date on or after the effective date of the act if the policyholder was issued a motor vehicle insurance policy or sent a renewal notice based on the assumption that the no-fault law would sunset.
- For a renewal policy, provide coverage with the same limits of PIP coverage, the same deductible from PIP coverage, and the same limits of medical payments coverage as provided in the prior policy, unless the policyholder elects different limits that are available.

[62] Section 627.736(5)(c)1.,F.S.
[63] The effective date is "upon becoming a law" which would presumably will be early October of 2007.

The effective date of the revised policy or renewal must be the same as the effective date specified in the prior notice. The revised notice of premium and coverage changes is exempt from the requirements of ss. 627.7277, 627.728, and 627.7282, F.S. (statutes governing notices of renewal premium, cancellations and nonrenewals, additional premium, and cancellation for nonpayment of premium).

Upon receiving the revised notice, the policyholder:

- Has a period of 30 days, or longer if specified by the insurer, to pay any additional amount of premium and maintain the policy in force.

- May instead cancel the policy within this time period and obtain a refund of the unearned premium.

- Will have their policy canceled by the insurer and receive any unearned premium if the policyholder fails to timely respond to the revised notice. The date on which the policy will be canceled must be stated in the revised notice and may not be less than 35 days after the date of the notice.

Failure of an insurer to timely mail or deliver a revised notice as required by this subsection does not affect the other requirements of this section.

With respect to a policy providing PIP coverage with an effective date between the effective date of this act (upon becoming law) and January 14, 2008, the insurer shall use the forms and rates it had in effect on September 30, 2007 (the last day before PIP was repealed) unless the insurer makes a new rate or form filing that is approved by the OIR or is otherwise legally allowed.

Persons who have been issued a motor vehicle insurance policy effective on or after October 1, 2007, and before the effective date of this act may continue to own and operate a motor vehicle in Florida and is not subject to any sanction for failing to maintain PIP coverage if:

- That person continues to meet the statutory requirement of maintaining property damage liability coverage; and

- Obtains PIP coverage no later than December 1, 2007.

A person with a policy that does not include PIP is not subject to the provisions of s. 627.737, F.S., relating to the exemption from tort liability with respect to injuries sustained by the person in a motor vehicle crash occurring while the policy without PIP coverage is in effect through November 30, 2007. Thus, such person may see recovery tort, and is not subject to the limitation on recovery for non-economic damages. Conversely, this person is also not immune from liability in tort, since such person is not required to have PIP and would not be protected from such liability pursuant to s. 627.737, F.S.

Every insurer must notify such policyholders by October 31, 2007, that the policyholder must obtain PIP that takes effect no later than December 1, 2007. The notice must include the premium for such coverage and any premium credit that should be provided for other coverage (such as bodily injury or uninsured motorist coverage) due to requirement in subsection (3) that the insurer must use the rates it had in effect on Sept. 30. Alternatively, the insurer may add an endorsement to the policy to provide PIP coverage, effective no later than December 1, 2007, without requiring any additional payment from the insured.

C. SECTION DIRECTORY:

Section 1. Amends s. 316.646, Florida Statutes, to require persons to have proof of property damage liability coverage while operating a motor vehicle (as currently required for PIP).

Section 2. Amends s. 320.02, Florida Statutes, to clarify the requirements concerning proof of insurance and liability coverage.

Section 3. Amends s. 321.245, Florida Statutes, relating to the use of certain funds in the Highway Safety Operating Trust Fund to correct a cross-reference.

Section 4. Amends s. 324.022, Florida Statutes, relating to property damage requirements for vehicle owners and operators and providing exception for active duty Armed Forces members.

Section 5. Creates s. 324.0221, Florida Statutes, relating to enforcement of mandatory PD and PIP coverage.

Section 6. Amends s. 627.7275, Florida Statutes, relating to motor vehicle insurance policies and contracts; conforming provisions to changes made by the act.

Section 7. Amends s. 627.7295, Florida Statutes, relating to motor vehicle insurance contracts, conforming provisions to changes made by the act.

Section 8. Revives and reenacts s. 627.730, Florida Statutes, entitling ss 627.730 through 627.7405, the Florida Motor Vehicle No-Fault Law.

Section 9. Revives and reenacts s. 627.731, Florida Statutes, containing a statement of purpose for the Florida Motor Vehicle No-Fault Law.

Section 10. Revives and reenacts s. 627.732, Florida Statutes, containing definitions applicable to the Florida Motor Vehicle No-Fault Law.

Section 11. Revives and reenacts and amends s. 627.733, Florida Statutes, regarding required security for the owners and operators of motor vehicles; conforms provisions to changes made by the act.

Section 12. Revives and reenacts s. 627.7347, Florida Statutes, relating to proof of security requirements and penalties.

Section 13. Revives and reenacts and amends s. 627.736, Florida Statutes, relating to required personal injury protection benefits, exclusions, priority and claims; conforming provisions to changes made by the act.

Section 14. Revives and reenacts s. 627.737, Florida Statutes, relating to exemption of tort liability for injuries payable through PIP benefits.

Section 15. Revives and reenacts s. 627.739, Florida Statutes, relating to PIP deductibles.

Section 16. Revives and reenacts s. 627.7401, Florida Statutes, relating to the notification of insured's rights.

Section 17. Revives and reenacts s. 627.7403, Florida Statutes, relating to the mandatory joinder of derivative claims.

Section 18. Revives and reenacts s. 627.7405, Florida Statutes, relating to insurers' rights of reimbursement when claims involved commercial vehicles.

Section 19. Provides legislative intent and codifies the revived and amended Florida Motor Vehicle No-Fault Law as ss 627.730-627.7405, Florida Statutes, despite those sections being previously repealed.

Section 20. Effective January 15, 2008, and applicable to policies issued on or after that date, amends s. 627.736, Florida Statutes, revision provisions governing the medical benefits provided as required PIP benefits; providing medical benefits for services and care ordered or prescribed by a physician or provided by certain persons or entities that meet certain requirements; requiring the Financial services Commission to adopt rules; revising a limitation on the amount of death benefits payable; requiring personal injury protection insurers to reserve benefits for certain providers for a specified period; tolling the time period for the insurer to pay claims from other providers; authorizing an insurer to limit reimbursement for personal injury protection benefits to a specified percentage of a schedule of maximum charges; prohibiting provider from billing or attempting to collect amounts in excess of such limits, except for amounts that are not covered by personal injury protection coverage; deleting provisions specifying allowable amounts for certain tests and services; providing for electronic transmission of certain statements; extending the period during which an insurer may pay an overdue claim following receipt of a demand letter without incurring a penalty; providing for penalties to be imposed against certain insurers for failing to pay claims for personal injury protection; authorizing the Department of Legal Affairs to investigate violations and initiate enforcement action; requiring that all claims related to the same health care provider for the same injured person be brought in one act unless good cause is shown; requiring that the transmission of electronic notices and communications required or authorized under the Florida Motor Vehicle No-Fault Law be consistent with state and federal privacy and security laws relating to required PIP benefits and claims; specifies medical providers eligible for reimbursement; allocates benefits for death and emergencies; provides a medical fee schedule; labels failure to pay claims an unfair, deceptive practice; requires joinder of related claims.

Section 21. Effective January 15, 2008, and applicable to policies issued on or after that date, amends s. 627.739, Florida Statutes, relating to optional limitations and deductibles on personal injury protection.

Section 22. Provides legislative intent as to what auto insurance policies will be affected by the act; provides procedures and requirements for transitional period.

Section 23. Provides act is effective upon being law, except where otherwise proved.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   Insurers will have to make form and rate filings with the Office of Insurance Regulation to meet the new requirements for PIP policies that will take effect January 15, 2008. The Office anticipates that it may have a nonrecurring fiscal impact due to the temporary substantial increase in workload.

   At present, the Office has 2 forms staff and 5 rates staff that are responsible for the review and approval/disapproval of auto filings. Last year staff processed approximately 1,549 auto form and rate filings in a 12 month period. Although it is unknown how many filings will be received, it will be difficult for Office staff to properly review the filings without additional resources or additional time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurers and policy holders may realize a savings due to a projected decline in motor vehicle insurance fraud.

D. FISCAL COMMENTS:

Since the requirement of having personal injury protection benefits is reinstated, there will be no net fiscal impact on state government. Revenues to the Department of Highway Safety and Motor Vehicle from license reinstatement fees should remain constant and revenues to the General Revenue Fund from insurance premium tax should remain constant.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill also provides that the Financial Services Commission adopt by rule the form that must be used by an insurer and a health care to document that the health care provider meets the applicable criteria to be eligible to provide services for PIP benefits and the rule must include a requirement for a sworn statement or affidavit.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On October 3, 2007, the Committee on Insurance adopted one amendment that restored the requirement that insurers must offer PIP polices with deductibles in amounts of $250, $500, and $1,000. The bill had previously repealed the deductible requirement for polices issued or renewed on or after January 15, 2008.

On October 4, 2007, the Jobs & Entrepreneurship Council adopted seven amendments. The amendments:

- Clarified that any care that is lawfully supervised by a physician is required to be covered by PIP.

- Provided that MRI's must be covered if the MRI has been lawfully ordered by a licensed health care provider.

- Included dentists within the types of physicians for whom $5,000 must be reserved to pay claims for emergency services and care or hospital inpatient care.

- Clarified that there is no tolling of the time period by which an insurer must pay a provider for treatment with regard to the $5,000 of PIP benefits not held in reserve to pay physicians rendering emergency or inpatient care in a hospital.

- Provided that for non-hospital services covered under Medicare Part B, the fee schedule may not be less than the 2007 Medicare fee schedule.

- Provided that if all parties mutually and expressly agree, any notice or documentation that is required or authorized under the no-fault law may be transmitted electronically, if done so by secure electronic data transfer that is consistent with state and federal privacy laws.

- Prohibits the use of a contingency risk multiplier in the calculation of attorney's fees due under the No Fault law.

- Restricts the amount of attorney's fees due under the No Fault law to the greater of $10,000 or three times the amount of benefits secured by the attorney.