HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCSMB for CS/CS/HB 967 and CS/HB 1411 Motor Vehicle Insurance
SPONSOR(S): Civil Justice Subcommittee, Insurance & Banking Subcommittee, Horner, Boyd
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Shaw	Gormley

SUMMARY ANALYSIS

Private passenger motor vehicle insurance rates in Florida are among the highest in the country. In 2008, only three jurisdictions had higher rates than Florida. The January 26, 2011 meeting of the Insurance & Banking Subcommittee of the Florida House of Representatives was devoted to this type of insurance. Much of the testimony provided at that meeting related to personal injury protection (PIP) fraud.

PIP is no-fault motor vehicle insurance. Florida motorists are required to carry at least $10,000 of PIP coverage. PIP provides payment of medical, surgical, funeral and disability benefits to the named insured and persons injured while in, or struck by, the insured motor vehicle without regard to fault. In return for assurance of payment of these benefits, the law places limitations on lawsuits for non-economic damages (pain and suffering).

The bill makes various changes to the private passenger motor vehicle insurance system:

- Provides legislative findings and intent as to motor vehicle insurance fraud.
- Requires long-form crash reports to be filed in additional circumstances.
- Caps attorney fee awards in PIP disputes at $200 per billable hour; bars the use of contingency risk multipliers in determining PIP fee awards.
- Incorporates by reference all provisions of the No-Fault Law into every PIP policy.
- Defines “claimant” and “entity wholly owned” under the No-Fault Law.
- Makes compliance with policy terms, including submission to examination under oath (EUO), by insureds and assignees of PIP benefits, a condition precedent to eligibility for policy benefits.
- Entitles medical providers to reasonable compensation for attending an EUO.
- Tolls the 30-day period for payment of PIP benefits when there is reasonable belief that insurance fraud has been committed.
- Establishes that a premature pre-suit demand letter for unpaid PIP benefits is defective.
- Creates a rebuttable presumption that an insured’s failure to appear for two scheduled examinations (mental or physical) is an unreasonable refusal to submit to examination.
- Provides that submission to examination is a condition precedent to eligibility for policy benefits.
- Permits licensed acupuncturists to receive PIP reimbursement.
- Preempts certain local lien laws with respect to payment of PIP benefits to medical providers.
- Bars payment of PIP benefits to persons who submit false statements or commit fraudulent insurance acts.
- Amends the PIP schedule of maximum charges.
- Authorizes insurers to deny payment for medical services when submitted documents are not considered to be signed or countersigned by the insured.
- Specifies penalties against health care providers and entities authorized to receive PIP reimbursement, and against persons who make false and fraudulent false and fraudulent insurance claims in order to receive proceeds from motor vehicle insurance contracts.

To the extent that the bill decreases fraudulent PIP claims, it will lower the cost of PIP insurance for Florida motorists.

The bill is effective July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Private Passenger Motor Vehicle Insurance in Florida

Private passenger motor vehicle insurance rates in Florida are among the highest in the country. For 2008, the estimated average expenditure for such insurance in the state was $1,055; only the District of Columbia, Louisiana, and New Jersey had higher rates.[1] In 2009, Floridians spent over $11.9 billion on private passenger motor vehicle insurance, making the Florida market the third largest in the nation.[2] More than 60 percent of the Florida market is written by ten insurance companies.[3]

The January 26, 2011 meeting of the Insurance & Banking Subcommittee of the Florida House of Representatives was devoted to private passenger motor vehicle insurance in Florida. Industry experts testified about rampant fraud in Florida's personal injury protection (PIP, or no-fault motor vehicle insurance) system and the cost of fraud to Florida motorists. Staged accidents, health care clinic fraud, and persons falsely alleging to be passengers at the time of an accident were among the problems discussed.[4] The Subcommittee heard testimony that PIP costs are rising at 70 percent a year, that PIP fraud costs will approach $1 billion in 2011, and that the typical two-car family will pay up to $100 in added premiums to pay for PIP fraud, which was referred to as a "fraud tax" on consumers.[5]

History of Florida's Motor Vehicle No-Fault System

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan, which took effect January 1, 1972. Under a no-fault system, medical and other benefits are provided without regard to fault in return for limitations on lawsuits for non-economic damages. Since its enactment, various changes have been made to the No-Fault Law.

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

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

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[1] Insurance Information Institute, "Auto Insurance," citing data of the National Association of Insurance Commissioners. Available at: http://www.iii.org/facts_statistics/auto-insurance.html (last accessed March 20, 2011).

[2] Florida Office of Insurance Regulation, "State of the Market: Property & Casualty Report" (December 17, 2010). On file with staff of the Insurance & Banking Subcommittee.

[3] *Id.* at 27. State Farm Mutual (19.8 percent market share) and Geico General (8 percent market share) are the largest writers of private passenger automobile insurance in Florida.

[4] The meeting packet is available at the Florida House of Representatives' website: http://www.myfloridahouse.gov/Sections/Committees/committeesdetail.aspx?SessionId=66&CommitteeId=2607 (last accessed March 20, 2011).

[5] See the Insurance Information Institute's presentation at the January 26th meeting of the Insurance & Banking Subcommittee.

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

[7] Chapter 2003-411, L.O.F.

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

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

Current PIP Provisions

Florida is one of 12 states[9] with no-fault motor vehicle[10] insurance provisions. PIP provides $10,000 of coverage (per person) for bodily injury sustained in a motor vehicle accident by the named insured, relatives residing in the same household as the named insured, persons operating the insured motor vehicle, passengers in the insured motor vehicle, and persons struck by the motor vehicle. PIP benefits are payable as follows:

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

PIP provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries. Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:[11]

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

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

Florida Traffic Crash Reports

Under s. 316.066, F.S., a crash report (long form) is required to be filed by a law enforcement officer with the Department of Highway Safety and Motor Vehicles only when the accident:

- Results in injury or death.
- Involves a hit and run or intoxicated driver.
- Results in a car being towed from the accident scene.

In other cases, a short-form crash report may be completed by a law enforcement officer or the parties involved in the accident.

[8] The Motor Vehicle No-Fault Law was repealed pursuant to s. 19, ch. 2003-411, F.S.

[9] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance systems. See the Insurance Information Institute's update on "No-Fault Auto Insurance." Available at: http://www.iii.org/media/hottopics/insurance/nofault/ (last accessed: March 20, 2011).

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

[11] Section 627.737, F.S.

Insurer Payment of PIP Claims and "Overdue" Benefits

PIP insurance benefits are payable by the insurer within 30 days after receipt of a covered loss and the amount due. Benefits not paid within this time are overdue.[12] Before filing a lawsuit for overdue PIP benefits, the aggrieved person must give the insurer written notice of intent to sue.[13] If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer.

Attorney Fee Awards to "Prevailing" PIP Claimants

Lodestar Calculation

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court calculates the lodestar, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[14]

In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar:[15]

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood, if apparent to the client, that acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

Contingency Risk Multiplier

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the lodestar in determining the fee award.[16] For example, if the lodestar was $20,000 and the court determined it appropriate to apply a contingency risk multiplier of 2.5, the fee award would be $50,000 ($20,000 lodestar x 2.5).

The Florida Supreme Court, in *Florida Patient's Compensation Fund v. Rowe*,[17] authorized the use of contingency risk multipliers in personal injury cases on two grounds:

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

Subsequently, in *Standard Guaranty Insurance Co. v. Quanstrom*,[18] the Court clarified that use of a contingency risk multiplier was not mandatory, but was within the trial court's discretion.

[12] Section 627.736(4)(b), F.S.
[13] Section 627.736(10), F.S.
[14] The federal lodestar approach to determining fee awards was adopted by the Florida Supreme Court in *Florida Patient's Compensation Fund v. Rowe*, 472 So.2d 1145 (Fla. 1985).
[15] *See* Rule 4-1.5(b) of the Rules Regulating the Florida Bar.
[16] *Standard Guaranty Insurance Co. v. Quanstrom*, 555 So.2d 828 (Fla. 1990).
[17] 472 So.2d 1145 (Fla. 1985).
[18] 555 So.2d 828 (Fla. 1990).

In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[19]

Currently there is a split of authority between the First and Fifth District Courts of Appeal with respect to the evidence required to support the use of a contingency risk multiplier in calculating a fee award under s. 627.428, F.S. In *Progressive Express Insurance Co. v. Schultz*,[20] the 5th DCA held that use of a contingency risk multiplier in a PIP action was improper because the policyholder did not testify that he had any difficulty obtaining legal representation, there was no evidence presented on the issue, and the lawsuit was essentially a straightforward contract case involving $1,315. In *Massie v. Progressive Express Insurance Co.*,[21] the issue before the 1st DCA was whether use of a contingency risk multiplier was proper when the PIP claimant did not testify that she had difficulty obtaining counsel, but expert testimony was offered that the claimant would have had such difficulty without the opportunity for a multiplier. On direct appeal, the 1st DCA, relying on *Schultz,* held that use of a multiplier was improper, and the claimant petitioned for certiorari review. Based on case law within the 1st DCA, the 1st DCA granted the petition, quashed the order on direct appeal, and affirmed the trial court's used of a contingency risk multiplier based on expert testimony.

Examinations of Insureds and Examinations Under Oath

In *Custer Medical Center v. United Automobile Insurance Co.*,[22] a passenger injured in an automobile accident failed to appear for two medical examinations requested by the insurer. At the time the requests were made, the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Florida Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer on the following grounds. Attendance at a medical examination is not a condition precedent to the existence of an automobile insurance policy. A dispute concerning attendance at a medical examination concerns an insured's right to receive "subsequent" PIP benefits pursuant to s. 627.736(7)(b), F.S., under an existing insurance policy, and is not a dispute about the policy's existence. Additionally, s. 627.737(7), F.S., provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits. Here, it was not shown that the injured passenger's failure to attend medical examinations constituted an "unreasonable refusal" to submit to examination. Further, the claim sought payment for medical services that had been provided before, and not after, the passenger failed to appear for examination.

Assignment of PIP Benefits

In *Shaw v. State Farm Fire and Casualty Co.*,[23] the 5th DCA held that policy language that required any person making a claim or seeking payment to submit to an examination under oath (EUO) did not require a health care provider who had been assigned PIP payment rights for services rendered to submit to an EUO. The 5th DCA based its decision on the following:

- The assignment of rights to the health care provider did not entail an assignment of duties.
- Section 627.736(6)(b), F.S., provides the mechanism for insurers to obtain information from health care providers concerning treatment and expenses.
- If there is a dispute regarding an insurer's right to discover facts from a health care provider, the insurer, under s. 627.736(6)(c), F.S., has the right to petition the court for a discovery order.

As the en banc decision was not unanimous and had a potential wide ranging impact, the 5th DCA certified the following question of great public importance to the Florida Supreme Court:

[19] *See Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[20] 948 So.2d 1027 (Fla. 5th DCA 2007).
[21] 25 So.3d 584 (Fla. 1st DCA 2009).
[22] 2010 WL 4344089 (Fla.).
[23] 37 So.3d 329 (Fla. 5th DCA 2010).

Whether a health care provider who accepts an assignment of no-fault insurance proceeds in payment of services provided to an insured can be required by a provision in the policy to submit to an examination under oath as a condition to the right of payment?

The Health Care Clinic Act

Part X of chapter 400, F.S., contains the Health Care Clinic Act (the act) (ss. 400.990-400.995, F.S.). The act was passed in 2003 to reduce fraud and abuse in the PIP insurance system.

Pursuant to the act, the Agency for Health Care Administration (AHCA) 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 which tenders charges for reimbursement for such services…") must be licensed as a clinic.[24] Every entity that meets the definition of a "clinic" must maintain a valid license with the AHCA at all times.[25] A clinic license lasts for a 2-year period. 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 chapter 435, F.S., is required of each applicant for clinic licensure. 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 specified activities on behalf of the clinic.

Although all clinics must be licensed with the AHCA, s. 400.9905(4), F.S., contains a listing of entities that are not considered a "clinic" for purposes of licensure. [26]

Effect of the Bill:

Legislative Findings and Intent

The bill states the Legislature's intent to balance the interests in the prompt payment of valid PIP claims with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. It also sets forth the following legislative findings:

- Motor vehicle insurance fraud is a major problem for consumers and insurers.
- The regulatory process for licensing health care clinics under the Health Care Clinic Act, part X, chapter 400, F.S., is not adequately preventing PIP fraud.

The Legislature also expresses its intent that:

- Insurers properly investigate claims and be allowed to obtain examinations under oath and sworn statements from PIP claimants and mental and physical examinations of insureds.
- False, misleading, or otherwise fraudulent activity associated with a PIP claim renders invalid the entire claim made by the person engaging in that activity.
- The 30-day period within which insurers are required to pay PIP benefits be tolled as to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed.
- Insurers discover the names of all passengers involved in automobile accidents before paying claims or benefits. A person who is not named in an accident report is presumed not to have been involved in the accident. However, such presumption can be overcome by evidence to the contrary.

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

[25] As of January 20, 2011, AHCA regulates 3,417 licensed health care clinics throughout Florida. See AHCA's presentation at the January 26, 2011 meeting of the Insurance & Banking Subcommittee. Available at the Florida House of Representatives' website.

[26] As of January 20, 2011, 7,956 entities held an exemption from health care clinic licensure. Since clinic exemptions are voluntary and there is no requirement to report the closure of a business, the number of exempt organizations that are still active is unknown. See AHCA's presentation at the January 26, 2011 meeting of the Insurance & Banking Subcommittee. Available at the Florida House of Representatives' website.

Crash Reports

The bill requires that long-form crash reports be filed with the Department of Highway Safety and Motor Vehicles in two additional circumstances:

- When any person involved in a motor vehicle accident complains of pain or discomfort.
- When a motor vehicle accident involves one or more passengers.

All crash reports are required to include the following information:

- The date, time, and location, of the crash.
- A description of the vehicles involved.
- The names and addresses of the parties involved and witnesses.
- The name, badge number, and law enforcement agency of the officer investigating the crash.
- The names of the respective parties' insurance companies.

Long-form crash reports also must include the names and addresses of all passengers involved in the crash, and clearly identify each such person as a passenger, including identifying the vehicle in which he/she was a passenger.

Investigating officers may testify at trial or provide a signed affidavit to confirm or supplement the information in any crash report.

Short-form crash reports prepared by law enforcement officers must be maintained by the officer's agency.

Proof of Eligibility for PIP Reimbursement

Upon initial submission of a claim, the following entities or licensed health care clinics are required to submit information, on a form adopted by the Department of Financial Services, demonstrating that it is eligible to receive PIP reimbursement, which includes a sworn statement or affidavit to that effect:

- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parents, children, or siblings.
- An entity wholly owned by a hospital or hospitals.
- Licensed health care clinics that are accredited by a specified accrediting organization.
- Licensed health care clinics that have a medical director that is a Florida licensed physician, osteopath, or chiropractor; that have been continuously licensed for more than three years or are a publicly traded corporation; and that provide at least four of eight specified medical specialties.

If a change in ownership occurs, a new form must be filed within 10 days. When a claim is denied for failure to provide this information, the entity or health care clinic has 30 days in which to file a properly completed form; otherwise, the insurer is not required to pay the claim.

Payment of PIP Benefits

For purposes of determining the extent to which the payment of PIP benefits is overdue, payment is considered made on the date it is mailed to the claimant, or if not mailed, on the date payment is delivered. An insurer that denies a claim in whole or in part, but fails to provide an itemized specification or explanation of benefits, does not waive other grounds for rejecting an otherwise invalid claim. Further, an insurer may obtain evidence and assert any ground for adjustment or rejection of claim even after a lawsuit has been filed.

The 30-day period within which insurers must pay PIP benefits is tolled when the insurer has a reasonable belief that a fraudulent insurance act has been committed. In these circumstances, the insurer is required to provide the claimant with written notice that it is investigating a fraudulent insurance act within 30 days after the date of its reasonable belief. Such claims must be paid or denied, in whole or in part, by the insurer within 15 days of completion of its investigation. Benefits due, but not

paid, within this time are considered overdue. Interest on these overdue claims is calculated from the day that benefits would have been considered overdue had the payment period not been tolled.

No PIP benefits, even for portions of a claim that are legitimate, are due or payable to or on behalf of an insured, claimant, or medical provider who has:

- Submitted a false statement document, record, or bill.
- Submitted false information.
- Otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989, F.S.

However, payment may not be denied to a medical provider solely because another medical provider or claimant has engaged in such misconduct. Additionally, insurers are authorized to recover any sums paid to claimants who have engaged in these activities and may bring legal action against the claimant.

If a physician, hospital, clinic, or other medical institution is ineligible for benefits under these circumstances, the injured party is not liable for unpaid charges and may not be billed. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

Schedule of Maximum Charges

The bill permits insurers to provide reimbursement under the PIP schedule of maximum charges for care and services rendered by ambulatory surgical centers and clinical laboratories (reimbursed at 80 percent of 200 percent of Medicare Part B) and for durable medical equipment [under the Durable Medical Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule of Medicare Part B]. Further, when reimbursement is made under a Medicare-based schedule of maximum charges, the applicable Medicare schedule in effect on January 1st is to be used throughout the year in calculating reimbursement, regardless of any subsequent changes in Medicare rates. As of January 1, 2012, insurers may use the PIP schedule of maximum charges only if the insurance policy provides a notice at the time of issuance or renewal that the insurer may limit reimbursement under the schedule. If a medical provider submits a charge for an amount less than that provided in the schedule of charges, the insurer may pay the charge submitted.

Disclosure and Acknowledgment Form, Billing Forms, and Patient Logs

A disclosure and acknowledgment form (at the initial treatment or service provided) or patient log (for subsequent services) that simply lists CPT codes or other medical codes cannot be "countersigned" by the insured, as the insured cannot attest to the fact that the services listed on the form were actually rendered. An insurer is not considered to have been furnished with notice of the amount of a covered loss or medical bills until it receives a properly countersigned disclosure and acknowledgment form that complies with all statutory requirements.

Except for emergency services and care, an insurer or insured is not required to pay a claim if the insured failed to countersign a billing form or patient log related to the claim or charges. The failure to submit a countersigned billing form or patient log creates a rebuttable presumption that the insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the treatment and loss until it can verify that the insured received the treatment. When a claim is denied on such grounds, the provider has 30 days from receipt of the denial to submit properly countersigned documents. If the provider fails to do so, the insurer is not required to pay the claim. The countersignature requirement is not satisfied by a statement that the insured's signature is "on file" or any similar statement.

Denial of Claim for Improperly Completed Statement or Bill

When a claim is denied due to a provider's failure to submit a properly completed statement or bill, the insurer must notify the provider about the provisions that were improperly completed. The provider may then resubmit the claim for payment within 30 days. If it fails to do so, the insurer is not required to pay the claim.

Examinations Under Oath

All insureds and assignees of PIP policy benefits, including medical providers, are required to comply with the terms of PIP policies, including submitting to an examination under oath (EUO). Compliance with policy terms by assignees and insureds is a condition precedent to the recovery of PIP benefits. Before requesting that an assignee participate in an EUO, the insurer must request the information sought in writing. An EUO may be recorded.

When an insurer requests that a medical provider submit to an EUO, the provider must produce persons who have the most knowledge of the issues identified by the insurer. Medical providers are entitled to reasonable compensation for attending an EUO, which must be paid prior to the EUO. If additional time is needed to complete the examination, the insurer must pay additional compensation within 15 days if the provider completes the EUO. Medical providers, at their own expense, may have an attorney present during the examination. Insurers that, as a general business practice, request EUOs of assignees without a reasonable basis commit an unfair and deceptive trade practice.

Mental and Physical Examinations

When an insured "unreasonably refuses" to submit to examination (mental or physical), the insurer is not liable for benefits incurred after the date of the first request for examination until the insured appears for examination. The failure of an insured to appear for two scheduled examinations creates a rebuttable presumption that the failure was an "unreasonable refusal" to submit to examination. Submission to examination is a condition precedent to eligibility for policy benefits.

Demand Letter

A demand letter that does not satisfy statutory criteria or that is sent during the pendency of a lawsuit is defective. A premature demand letter cannot be cured unless the action is abated by the court or voluntarily dismissed by the plaintiff.

If a claimant disputes the amount paid by an insurer in response to a demand letter, he/she must send the insurer a second demand letter by certified or registered mail. The second letter must state the exact amount the claimant believes he/she is owed and why the insurer's payment was incorrect. The insurer then has 10 days from receipt of the second demand letter to make any additional payment that is owed.

Attorney Fees

Attorney fee awards in PIP disputes are limited to $200 per billable hour, and the use of contingency risk multipliers is barred in calculating PIP fee awards.

Civil Penalties

Licensed health care practitioners or persons who own entities eligible to receive PIP reimbursement who are found guilty of insurance fraud related to motor vehicle insurance under s. 817.234, F.S. ("False and fraudulent insurance claims") will lose their occupational license or practice license for five years and may not receive reimbursement for PIP benefits for 10 years.

In addition to criminal sanctions, a person convicted of violating s. 817.234, F.S., is subject to the following civil penalties:

- A fine of up to $5,000 for the first offense.
- A fine ranging from $5,000 to up to $10,000 for a second offense.
- A fine greater than $10,000 and up to $15,000 for a third or subsequent offense.
- A fine of $15,000 to $50,000 for violation of s. 817.234(9), F.S. (relating to staged accidents and schemes to create documentation of a motor vehicle crash that did not occur).

These civil penalties are to be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used for the investigation and prosecution of insurance fraud.

State attorneys are not prohibited from entering into written agreements in which persons charged with violating s. 817.234, F.S., do not admit to or deny the charges but consent to payment of the civil penalty.

Miscellaneous

- Defines PIP "claimant" as any person, organization, or entity seeking benefits, including assignees.
- Defines "entity wholly owned" as a proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners. To be wholly owned, licensed health care practitioner(s) must be the business owner(s) of all aspects of the business entity, exercise ultimate authority over personnel and compensation, be reflected as the business owner(s) on the physical facility lease or ownership, file taxes as the owner(s), own the entity bank account, and be listed as the principal(s) on all incorporation documents. The definition is designed to clarify what constitutes an entity wholly owned by licensed health care providers for purposes of eligibility to receive reimbursement for PIP medical services.
- Permits acupuncturists who are licensed exclusively to provide oriental medicine to receive reimbursement for PIP medical services.
- Preempts local lien laws and prevents them from applying to the requirement that insurers reserve $5,000 of PIP benefits for payment of emergency services and hospital inpatient care.
- For the first billing cycle only, permits health care providers that timely provide notice of initiation of treatment to include charges for treatment that was rendered up to 75 days before the postmark date on the statement of charges received by the insurer.
- Establishes that all provisions, schedules, and procedures of the Florida Motor Vehicle No-Fault Law are incorporated by reference into every PIP insurance policy and that insurers are not required to amend their policies to implement these provisions.
- Requires PIP insureds, claimants, and medical providers to provide the insurer, upon request, with copies of treatment and examination records to be used by a physician for a records review, which is not required to be based on a physical examination and may be obtained by the insurer at any time. Tolls the 30-day period for payment of PIP claims from the date the insurer requests treatment records to the date the insurer receives the treatment records. Allows medical providers to charge for the cost of copying records and postage, not to exceed $1 per page for the first 25 pages and 25 cents per page for subsequent pages. Permits imposition of reasonable costs for reproducing X rays and other image-based records, including actual cost of material and supplies to duplicate the record, and labor costs and overhead costs associated with the duplication. Permits insurers to deny benefits to insureds, claimants or medical providers that fail to cooperate in the insurer's investigation or commit fraud or a material misrepresentation.
- Permits insurers to conduct an onsite physical review and examination of a provider's or entity's treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request.

B. SECTION DIRECTORY:

Section 1. Provides legislative findings and intent relating to motor vehicle insurance fraud.

Section 2. Amends s. 316.066, F.S., relating to written reports of motor vehicle crashes.

Section 3. Creates s. 627.711, F.S., incorporating by reference all provisions, schedules, and procedures of the Florida Motor Vehicle No-Fault Law into all PIP insurance policies.

Section 4. Amends s. 627.732, F.S., defining "claimant" and entity wholly owned" under the Florida Motor Vehicle No-Fault Law and amending other definitions.

Section 5. Amends s. 627.736, F.S., authorizing PIP reimbursement for acupuncturists; relating to reimbursement of certain entities under PIP; tolling the 30-day PIP payment period when fraud is reasonably suspected; denying receipt of any benefits to claimants who commit fraud as to any portion of a claim ; providing for insurers to obtain records for a records review; amending PIP schedules of maximum reimbursement; establishing the appropriate schedule to use for PIP reimbursement under a Medicare-based schedule of maximum charges; providing that insurers are not liable to pay claims when billing forms and patient logs are defective; specifying that countersigned means a second or verifying signature; permitting certain charges to be included in a provider's first billing cycle; allowing providers who have not submitted a properly completed statement or bill to resubmit a properly completed statement within 30 days; providing that an insufficient disclosure and acknowledgment form does not provide the insurer with notice of the amount of a covered loss or medical bills; providing that the failure to maintain patient logs as required by statute renders the treatment provided noncompensable; permits insurers to conduct onsite physical reviews and examinations of treatment locations and apparatuses; requiring assignees of PIP policy benefits to comply with all policy terms, including submission to an examination under oath; providing that submission to an examination under oath (EUO) is a condition precedent to PIP recovery; requiring insurers to request information in writing before requesting an assignee to participate in an EUO; providing for reasonable compensation for medical providers who attend and EUO; providing that insurers that, as a general business practice, request EUOs of assignees without a reasonable basis engage in an unfair and deceptive trade practice; creating a rebuttable presumption that the failure to appear for two scheduled examinations constitutes an "unreasonable refusal" to submit to examination; establishing that a premature demand letter is defective, which cannot be cured unless the court abates the action or the action is voluntarily dismissed; requiring claimants to send a second demand letter under specified circumstances.

Section 6. Amends s. 817.234, F.S., providing for loss of professional and occupational licenses for insurance fraud and civil penalties.

Section 7. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Highway Safety and Motor Vehicles estimates that enactment of the bill would result in its receipt of approximately 90,000 additional long-form crash reports per year. Based on its current contract for processing crash reports, the Department estimates that the maximum cost to process these reports would be $104,687 per year.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

To the extent that local law enforcement officers are required to complete and file additional crash reports, additional law enforcement resources would be utilized.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the bill decreases PIP fraud, the bill will lower the cost of fraud and decrease the cost of PIP insurance for Florida motorists.

D. FISCAL COMMENTS:

PIP fraud has been identified as a major problem in Florida and contributes to the high cost of motor vehicle insurance.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES