IMPACT ANALYSIS OF HB 119

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Purpose and Scope

Pinnacle Actuarial Resources, Inc. (Pinnacle) was retained by the Florida Office of Insurance Regulation (OIR) to conduct an independent actuarial study to calculate the savings to be expected as a result of FL HB 119. Pinnacle is well qualified to do this study by virtue of extensive experience with personal and commercial automobile insurance, experience with the Florida insurance marketplace and a significant number of assignments involving legislative costing of no-fault reforms and initiatives.

Distribution and Use

This report is being provided to the Florida OIR for its use and the use by the makers of public policy in evaluating the expected savings resulting from Florida HB 119. Specifically, the Office of Insurance Regulation must present a report of the expected savings from the act to the Governor and Legislature by September 15, 2012. Permission is hereby granted for this distribution on the condition that the entire report, including exhibits, is distributed rather than any excerpt. We are available to answer any questions that may arise regarding this report.

Our conclusions are predicated on a number of assumptions as to future conditions and events. Those assumptions, which are documented in subsequent sections of the report, must be understood in order to place our conclusions in their appropriate context. In addition, our work is subject to inherent limitations, which are also discussed in this report.

Reliances and Limitations

In our analysis, we relied on data from the following sources:

- Office of the Insurance Consumer Advocate, “Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection)”, December 2011
- Office of the Insurance Consumer Advocate, March 1, 2012 Update to “Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection)”, December 2011
- Florida Office of Insurance Regulation, “Report on Review of the 2011 Personal Injury Protection Data Call”, April 11, 2011

- Florida Department of Financial Services, Division of Insurance Fraud, "2009/2010 Fiscal Year Stat Pack Report"
- Florida Department of Financial Services, Division of Insurance Fraud, "2007/2008 Fiscal Year Stat Pack Report"
- Florida Department of Financial Services, Division of Insurance Fraud, "2005/2006 Fiscal Year Stat Pack Report"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2010"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2009"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2008"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2007"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2006"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2005"
- Florida Highway Safety and Motor Vehicles, "Traffic Crash Statistics Report 2004"
- Insurance Research Council,(IRC) "Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost and Compensation", January 2008
- Mitchell, Inc.
- National Insurance Crime Bureau, "ForeCAST Report – Florida Staged Accidents", June 23, 2010
- Property Casualty Insurers Association of America and Personal Insurance Federation of Florida, "Results from Recent Industry Survey on Florida Attorney Fees", November 11, 2011
- Property Casualty Insurers Association of America and Personal Insurance Federation of Florida, "Data Call Requested by Senator Joe Negron: Florida Auto No Fault Lawsuits and Attorney Fees", December 6, 2011
- Independent Statistical Service, Inc., "Florida Private Passenger Non-Fleet Excluding Assigned Risks Automobile Experience," 2008-2010
- Claims Surveys conducted by Pinnacle
- NAIC ISO, ISS, NISS Fast Track Private Passenger Auto Loss Data
- AM Best 2011 Aggregates and Averages

We have relied on the accuracy of the above data in our calculations. If it is subsequently discovered that the underlying data or information are erroneous, then our calculations would need to be revised accordingly.

We have also relied on a number of assumptions about the implementation of various provisions of HB 119 and other assumptions regarding the calculations contained herein. Those assumptions are described in detail later in this report.

We have relied upon a great deal of publicly available data and information, without audit or verification. However, we did review as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry and other sources. It is possible that the historical data used to make our estimates may not be predictive

of future loss and loss adjustment experience in Florida. We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the number or size of automobile insurance claims beyond those contemplated in HB 119.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

Executive Summary

We began our analysis with an extensive review of a variety of data sources regarding Personal Injury Protection (PIP) coverage benefits and payments in Florida. We also conducted a series of interviews with insurance company claims experts, OIR staff, the Florida Consumer Advocate and others. Based on data from the OIR PIP Data Call, which represents approximately 80% of the market, the number of PIP claims opened or recorded in 2010 was over 386,000, a 28% increase from 2006. During this same period, the dollars paid by insurers included in the OIR's PIP Data Call for PIP claims increased 66% from approximately $1.5 Billion in 2006 to approximately $2.5 Billion in 2010. This certainly indicates the magnitude of the problem.

We have reviewed the various changes in the statute in sixteen major categories. The analysis is laid out in detail later in this report. The overall result is an indicated savings in PIP claims losses of 16.3% to 28.7% and an indicated statewide average savings in PIP premiums of 14.0% to 24.6%. The cost estimates in this report are generally stated in terms of the impact on claim losses. The impact on claim losses cannot be used interchangeably with premium savings. This is because a portion of the insurance companies' expenses is for general overhead (rent, utilities, etc.) and would not decrease proportionately to the loss costs. Based on the 2011 Bests Aggregates and Averages, Private Passenger Automobile Liability general and other acquisition expenses represent 14.3% of the industry-wide written premium (this 14.3% does not include agents' commissions, premium taxes and other premium- related expenses). To estimate the PIP premium savings corresponding to the cost savings shown in this report, it is necessary to reduce

the cost savings by a factor of approximately .857. Thus a 16.3% cost savings equates to 14.0% premium savings. The savings shown assume that current rates are adequate. To the extent that current PIP rates are inadequate, it is likely that insurers will offset the savings from HB 119 against the otherwise indicated PIP rates. We would also emphasize that the above percentage savings are statewide averages for PIP coverage only. Actual savings are likely to vary by geographic region. Also, it should be recognized that PIP coverage amounts to only approximately 20% of the total personal auto premium paid for a full coverage policy.

It should be noted that injured accident victims in Florida whose medical bills are not paid by the $10,000 PIP benefit ($2,500 for non-emergency medical care) can sue for excess economic loss benefits (as well as "pain and suffering" if they meet the verbal threshold). The reduction of PIP benefits due to HB 119, will likely result in a commensurate, but smaller increase in Bodily Injury (BI) and Uninsured/Underinsured Motorists (UM/UIM) Coverage costs. As shown on the attached Exhibit 2, our best estimate of the indicated increase in BI/UM/UIM premiums due to HB 119 is + 3.0 to + 4.7%.

Finally, we would note that most of the changes to PIP coverage contained in HB 119 are effective on January 1, 2013. To the extent that these changes are implemented for new and renewal auto insurance policies issued on and after January 1, 2013, the savings will not be realized immediately on January 1, but only as policies are written or renewed on or after January 1. So for many policies the savings will not be realized until July 1, 2013 or later.

Background

Pinnacle was retained to research and perform an actuarial analysis to calculate the savings to be expected as a result of FL HB 119. This report is a summary of our findings.

In the 1971 legislative session, Florida adopted a no-fault automobile insurance plan which took effect on January 1, 1972. A no-fault plan is designed to quickly provide benefits for a person injured in an automobile accident, regardless of fault. A no-fault plan provides payment for medical, wage loss and death benefits, however it does limit the insured's right to sue for non-economic losses such as pain and suffering.

In 1974, the Supreme Court opined in *Lasky vs. State Farm Insurance Company* (296 So.2d 9 (Fla. 1974)) that the no-fault law was intended to:

- assure that persons injured in vehicular accidents would be directly compensated by their own insurer, even if the injured party was at fault, thus avoiding dire financial circumstances with the "possibility of swelling the public relief rolls;"
- lessen court congestion and delays in court calendars by limiting the number of law suits;
- lower automobile insurance premiums; and
- end the inequities of recovery under the traditional tort system.

The first party (policyholder) benefit coverage is known as personal injury protection (PIP), so the terms "no-fault" and "PIP coverage" are used interchangeably to denote an auto insurance program that allows policyholders to recover financial loss resulting from an automobile injury from their own insurer. PIP is coverage that pays for medical care and other benefits if the policyholder has an auto accident.

The Florida PIP law is designed to help reduce the need for people to sue to cover the cost of injuries resulting from automobile accidents. But the $10,000 minimum requirement for PIP coverage in Florida has become a "dollar target" for medical expenses by those who take advantage of the system.

Over the years, there have been many concerns over inflated claims, fraud and abuse of the system, and increasing premium and numbers of law suits filed under the no-fault system. In Special Session A of the 2003 Legislative Session, a sunset provision was passed that, effective October 1, 2007, repealed the Motor Vehicle No-Fault Law unless the Legislature reenacted the law prior to such date. While the sunset provision did take effect on October 1, 2007, the Legislature reenacted the no-fault law, effective January 1, 2008, with several changes (including use of fee schedules for some services) designed to help control medical costs.

Since the reenactment of the no-fault system, anecdotal data as well as insurers' own experience, has demonstrated a significant uptick in the claim experience of the PIP coverage provided under

the no-fault system. Many large insurers have found it necessary to file average statewide rate increases for PIP coverage exceeding 10% per year in several years. Changes by territory vary significantly. Anecdotally, these increases have been attributed to increased fraud activity.

HB 119 — Motor Vehicle Personal Injury Protection Insurance

The following description of HB 119 was taken from the Florida Senate's 2012 Summary of Legislation passed.

> HB 119 revises the Florida Motor Vehicle No-Fault Law. The bill primarily amends laws governing Personal Injury Protection (PIP) benefits under the No-Fault law and laws related to PIP motor-vehicle insurance fraud. The major changes enacted by the bill are as follows:
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> *PIP Medical Benefits*
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> The bill revises the provision of Personal Injury Protection medical benefits under the Florida Motor Vehicle No-Fault Law, effective January 1, 2013. Individuals seeking PIP medical benefits are required to receive initial services and care within 14 days after the motor vehicle accident. Initial services and care are only reimbursable if lawfully provided, supervised, ordered or prescribed by a licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. Follow up services and care require a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.
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> The bill applies two different coverage limits for PIP medical benefits, based upon the severity of the medical condition of the individual. An individual may receive up to $10,000 in medical benefits for services and care if a physician, osteopathic physician, dentist, physician's assistant or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part. An individual who is not diagnosed with an emergency medical condition, the PIP medical benefit limit is $2,500. Massage and acupuncture are not reimbursable, regardless of the type of provider rendering such services.
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> *PIP Death Benefit*
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> Personal Injury Protection now offers $5,000 in death benefits in addition to $10,000 in medical and disability benefits. Previously, the death benefit was the lesser of the unused PIP benefits, up to a limit of $5,000. The increased death benefit is effective January 1, 2013.

PIP Medical Fee Schedule

The bill revises provisions related to the PIP medical fee schedule in an effort to resolve alleged ambiguities in the schedule that have led to conflicts and litigation between claimants and insurers. The bill clarifies that the reimbursement levels for care provided by ambulatory surgical centers and clinical laboratories and for durable medical equipment is 200 percent of the appropriate Medicare Part B schedule. The Medicare fee schedule on effect on March 1 will be the applicable fee schedule for the remainder of that year until the subsequent update. Insurers are authorized to use Medicare coding policies and payment methodologies of the Centers for Medicare and Medicare Services, including applicable modifiers, when applying the fee schedule if they do not constitute a utilization limit. The bill also requires insurers to include notice of the fee schedule in their policies. These provisions are effective January 1, 2013.

Attorney Fees

The bill amends provisions related to attorney fee awards in No-Fault disputes. The bill prohibits the application of attorney fee multipliers. The offer of judgment statute, s. 768.79, F.S., is applied to No-Fault cases, providing statutory authority for insurers to recover fees if the plaintiff's recovery does not exceed the insurer's settlement offer by a statutorily specified percentage. The bill maintains current law allowing a party that obtains a favorable judgment from an insurer to recover reasonable attorney fees from the insurer. The bill also requires that the attorney fees awarded must comply with prevailing professional standards, not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity, and represent legal services that are reasonable to achieve the result obtained.

Investigation and Payment of Claims

Provisions relating to the investigation of PIP claims by insurers are revised, effective January 1, 2013. Insurers are authorized to take an examination under oath (EUO) of an insured. Compliance is a condition precedent for receiving benefits (the insurer owes zero benefits if the insured does not comply). An insurer that unreasonably requests EUOs as a general business practice, as determined by the Office of Insurance Regulation (OIR), is subject to s. 626.9541, F.S. of the Unfair Insurance Trade Practices Act. The bill also provides that if a person unreasonably fails to appear for an independent medical examination (IME), the carrier is no longer responsible for benefits. Refusal or failure to appear for two IMEs raises a rebuttable presumption that the refusal or failure was unreasonable.

Changes are made to the statutory process for the payment of PIP benefits, primarily to assist claimants in their claim submissions, effective January 1, 2013. A claimant whose claim is denied due to an error in the claim is given 15 additional days to correct the erroneous claim and resubmit it timely. The insurer must maintain a log of all PIP benefits paid on behalf of the insured and must provide the log to the insured upon his or her request if litigation has initiated. If a dispute between insurers and insureds occurs,

the insurer must provide notice within 15 days of the exhaustion of PIP benefits. Insurers must reimburse Medicaid within 30 days. The electronic submission of records is authorized, effective December 1, 2012.

Prevention of PIP-Related Insurance Fraud

House Bill 119 contains numerous provisions designed to curtail PIP fraud. The bill defines insurance fraud as knowingly presenting a PIP claim to an insurer for payment or other benefits on behalf of a person or entity that committed fraud when applying for health care clinic licensure, seeking an exemption from clinic licensure, or demonstrating compliance with the Health Care Clinic Law. Claims that are unlawful under the patient brokering law (s. 817.505, F.S.) are not reimbursable under the No-Fault Law. A health care practitioner found guilty of insurance fraud under s. 817.234, F.S., loses his or her license for 5 years and may not receive PIP reimbursement for 10 years. Insurers are provided an additional 60 days (90 total) to investigate suspected fraudulent claims, however, an insurer that ultimately pays the claim must also pay an interest penalty.

All entities seeking reimbursement under the No-Fault Law must obtain health care clinic licensure except for hospitals, ambulatory surgical centers, entities owned or wholly owned by a hospital, clinical facilities affiliated with an accredited medical school and practices wholly owned by a physician, dentist, or chiropractic physician or by such physicians and specified family members.

The bill creates standards for evaluating whether an entity claiming it is exempt from the requirement to obtain clinic licensure is actually wholly owned by a physician.

The bill defines failure to pay PIP claims within the time limits of s. 627.736(4)(b), F.S., as an unfair and deceptive practice. The OIR may order restitution to the insured or provider, but is not limited in its other administrative penalties, which may include suspending the insurer's certificate of authority.

Law enforcement is required to complete a long-form crash report when there is an indication of pain or discomfort by any party to a crash. All crash reports completed by law enforcement must identify the vehicle in which each party was a driver or passenger. For all crashes that do not require a law enforcement report, the vehicle driver must submit a report on the crash to the Department of Highway Safety and Motor Vehicles within 10 days of the crash.

The bill creates a non-profit direct support organization, the Automobile Insurance Fraud Strike Force, which can accept private donations for the purposes of preventing, investigating, and prosecuting motor vehicle insurance fraud. Monies raised by the Strike Force may fund the salaries of insurance fraud investigators, prosecutors, and support personnel so long as such grants or expenditures do not interfere with prosecutorial independence. Funds may not be used to advertise using the likeness or name of any elected official or for lobbying.

Mandatory Rate Filings and Data Call

The Office of Insurance Regulation must contract with a consulting firm to calculate the expected savings from the act, which must be presented to the Governor and Legislature by September 15, 2012. By October 1, 2012, each insurer that writes private passenger automobile personal injury protection insurance must submit a rate filing. If the insurer requests a rate that does not provide at least a 10 percent reduction of its current rate, it must explain in detail its reasons for failing to achieve those savings. A second rate filing must be made by January 1, 2014. If the insurer requests a rate that does not provide at least a 25 percent reduction of the rate that was in effect on July 1, 2012, it must explain in detail its reasons for failing to achieve those savings. The Office of Insurance Regulation must order an insurer to stop writing new PIP policies if the insurer requests a rate in excess of the statutorily required rate reduction and fails to provide a detailed explanation for that failure. The Office of Insurance Regulation must perform a comprehensive PIP data call and publish the results by January 1, 2015. The data call will analyze the impact of the act's reforms on the PIP insurance market.

Analysis

We began our analysis with an extensive review of a variety of data sources regarding PIP benefits and payments in Florida. These data sources are listed on page 2 and 3 of this report.

Based on data from the OIR PIP Data Call, which represents approximately 80% of the market, the number of PIP claims opened or recorded in 2010 was over 386,000, a 28% increase from 2006. During this same period, the dollars paid by insurers included in the OIR's PIP Data Call for PIP claims increased 66% from approximately $1.5 Billion in 2006 to approximately $2.5 Billion in 2010.

During that period, the number of PIP-related lawsuits pending at year end in which the insurer was the defendant increased by 387% and the number of such lawsuits settled during the year increased by 315%.

In order to address the cost savings in a comprehensive and orderly way, we have reviewed the various changes in the statute in sixteen major categories. The following chart summarizes our estimates of the impacts of the sixteen changes. It should be noted that some of the changes in the statute result in estimated increases in costs rather than savings. These items are shown as a

positive number as opposed to the negative numbers associated with the items anticipated to produce savings in the chart. Following the chart is a detailed explanation of each item and the rationale for our anticipated savings or cost.

Item #	Item Description	Lines	Minimum Impact	Central Impact	Maximum Impact
1	Expansion of Florida Traffic Crash Report Long Form	130-154	0.0%	-0.8%	-1.5%
2	Clinics must be Licensed	331-334	0.0%	0.0%	0.0%
3	Establish Automobile Insurance Fraud Strike Force	478-613	-0.5%	-1.3%	-2.0%
4	Separation of Death Benefit	668-669 & 777-781	0.6%	0.7%	0.8%
5	Initial Services within 14 Days	677-679	0.0%	-0.8%	-1.5%
6	Limitation on Non-Emergency Conditions	750-754	-9.8%	-12.3%	-14.7%
7	Exclusion of Massage Therapy & Acupuncture	755-776	-6.9%	-8.7%	-10.4%
8	Repay Medicaid within 30 Days	821-823	0.0%	0.0%	0.0%
9	Submission of Revised Claim within 15 Days	852-860	0.0%	0.0%	0.0%
10	Additional 60 Days for Fraud Investigation	964-975	0.0%	0.0%	0.0%
11	Report All Claims Denied for Fraud to Division of Insurance Fraud	975-977	0.0%	0.0%	0.0%
12	Fix Medicare Fee Schedule	*1049*-1057	0.0%	-0.8%	-1.5%
13	Insureds Must Comply with Policy Conditions/Examination Under Oath	1428-1439	0.0%	0.0%	0.0%
14	Insureds Refusal to Submit/Failure to Appear at 2 Medical Exams	1522-1525	-0.6%	-0.9%	-1.2%
15	Attorney Fees Calculated w/o Contingency Fee Multiplier	1543-1545	-0.2%	-0.2%	-0.2%
16	Loss of License to Practice for 5 Years/Reimbursement for PIP 10 Years	1746-1751	0.0%	0.0%	0.0%
(1)	Adjustment for Overlap		1.1%	2.4%	3.5%
(2)	Overall Anticipated Impact on Losses		-16.3%	-22.7%	-28.7%
(3)	General and Other Acquisition Expenses		14.3%	14.3%	14.3%
(4)	PIP Premium Savings		-14.0%	-19.5%	-24.6%

Calculation of the Premium and Cost Savings

Pinnacle began by determining the estimated minimum, maximum, and central impact for each individual item. These estimates are the impact for the individual item as if no other changes are taking place. However, there is overlap between the different items and the total must be adjusted for the overlap.

We reviewed the impact of each item sequentially and determined how much of the savings was already accounted for in the prior items. For example, take Item 7 – Exclusion of Massage Therapy & Acupuncture. Of the medical losses for claimants with initial services greater than 14 days from the date of accident (Item 5), 7% are for massage and acupuncture claims. For initial

claims (Item 6). Item 7 has overlaps of 7% with Item 5 and 8.2% with Item 6. These percentages were determined with the data provided by IRC. The loss overlap is calculated as 7% x Losses Eliminated for Item 5 + 8.2% x Losses Eliminated for Item 6. Overlaps were calculated similarly for Items 6 (Limitation on Non-Emergency Conditions) and 12 (Fix Medicare Fee Schedule). The overall adjustment for overlap is 1.1% - 3.5%. The Overall Anticipated Impact on Losses is the sum of the individual impacts plus the adjustment for overlap.

The cost estimates in this report are generally stated in terms of the impact on claim losses. The impact on claim losses cannot be used interchangeably with premium savings. This is because a portion of the insurance companies' expenses is for general overhead (rent, utilities, etc.) and would not decrease proportionately to the loss costs. Based on the 2011 Bests Aggregates and Averages, Private Passenger Automobile Liability general and other acquisition expenses represent 14.3% of the industry-wide written premium (this 14.3% does not include agents' commissions, premium taxes and other premium- related expenses). To estimate the premium savings corresponding to the cost savings shown in this report, it is necessary to reduce the cost savings by a factor of approximately .857. Thus a 16.3% cost savings equates to an approximate 14.0% premium savings.

The savings calculated assume that current rates are adequate. To the extent that current PIP rates are inadequate, it is likely that insurers will offset the savings from HB 119 against the otherwise indicated PIP rates. We would also emphasize that the above percentage savings are statewide averages for PIP coverage only. It is likely that actual savings will vary by geographic region. Also, it should be recognized that PIP coverage amounts to only approximately 20% of the total personal auto premium paid for a full coverage policy.

Finally, we would note that most of the changes to PIP coverage contained in HB 119 are effective on January 1, 2013. To the extent that these changes are implemented for new and renewal auto insurance policies issued on and after January 1, 2013, the savings will not be realized immediately on January 1, but only as policies are written or renewed on or after January 1. So for many policies the savings will not be realized until July 1, 2013 or later.

1. *Expansion of Florida Traffic Crash Report (lines 130-154 of HB 119).*

This portion of the statute expands the circumstances under which the Florida Traffic Crash Report, Long Form must be completed and its contents. One of the concerns which this section is addressing was the possibility that the driver and/or passengers of the vehicles involved in a traffic accident may be misreported including "phantom passengers" and "jump-ins" who might then receive fictitious treatment for their injuries to line the pockets of PIP clinics or fraudulent providers of medical services. In order to determine if there is evidence of this, we reviewed statistics of the ratio of injured passengers per accident and injured passengers per injured driver as well as the number of "claimants per claim". The data for injured passengers was taken from Florida Highway Crash Statistics. As shown on Exhibit 3, this data shows a decline in the number of injured passengers per accident and the ratio of injured passengers per injured driver during the period 2004-2007, followed by an increase in the ratios during 2008-2010. This data could indicate evidence of fraudulent activity in the most recent three years. We also examined data from Mitchell regarding the average number of claimants per claim (see Exhibit 3, page 2). This data showed an increase in the average number of claimants per claim in the period 2006-2009, followed by a decrease in 2010 and 2011. This data does not seem to provide evidence of phantom claiming behavior. So the evidence is mixed. The data on number of injured passengers per crash and per injured driver suggests an increase of approximately 3% in the last three years which could be the result of "phantom passengers". The average number of claimants per claim data would support 0% savings. We conclude that the savings from the use of the long form would indicate a possibility of savings in the 0-1.5% range (average of 0% and 3%).

2. *Clinics Licensing (Lines 331-334)*

This portion of the new statute provides that an entity providing PIP services shall be deemed a clinic and must be licensed in order to receive reimbursement under PIP. All entities seeking reimbursement under the No-Fault Law must obtain health care clinic licensure except for hospitals, ambulatory surgical centers, entities owned or wholly owned by a hospital, clinical

facilities affiliated with an accredited medical school and practices wholly owned by a physician, dentist, or chiropractic physician or by such physicians and specified family members.

The bill creates standards for evaluating whether an entity claiming it is exempt from the requirement to obtain clinic licensure is actually wholly owned by a physician or other defined medical service provider.

The statutory change addresses concerns that under the prior PIP statute, clinics could avoid being licensed which may have resulted in fraudulent activities by clinics that were not properly licensed.

In order to estimate the savings associated with this change in licensing, we would need to be able to estimate the percentage of PIP services being provided by unlicensed clinics, and then determine the portion of those PIP services being provided that were fraudulent. Once this is determined, the amount of potential savings needs to be mitigated because the licensing requirement will not automatically eliminate all fraud from that clinic since a previously unlicensed clinic could obtain a license and continue to perpetrate fraud.

In all the research that we have conducted, we were unable to determine an estimate of the percentage of PIP services that are currently being provided by unlicensed clinics. Also, in our interviews with insurer claim representatives, the estimate of the impact by different insurers varied. One insurer estimated the cost savings to be minimal; two others estimated some/marginal savings, while one insurer believes this provision will lead to big potential savings. One benefit of this provision would be the consolidation of some unlicensed clinics into licensed clinics, so the smaller number of clinics would be easier to track and monitor. This could potentially lead to large savings as this monitoring would be more effective at identifying and combating fraud. Offsetting these positive developments is the potential that even in licensed clinics, fraud could still be perpetrated. There is also the feeling that some of the licensure provisions could be difficult to enforce.

We believe that this change is a positive step in reducing potential fraud. We have not assigned a specific savings to it but have included this in our overall anti-fraud savings under item 3 below.

3. Establish Automobile Insurance Fraud Strike Force (Lines 478-613)

HB 119 provides for the establishment of the Automobile Insurance Fraud Strike Force (Strike Force). The sole purpose of the Strike Force is to "support the prosecution, investigation, and prevention of motor vehicle insurance fraud." Insurance companies are allowed to fund the Task Force activities; however, there are no specific activities required by HB 119 beyond the general mandate stated in their purpose. The Strike Force will be a direct support organization, supporting the anti-fraud efforts of the Division of Insurance Fraud of the Department of Financial Services (Division), state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration, and the Department of Health. As such, the Strike Force will not conduct anti-fraud activities itself, but will work with other state agencies to support anti-fraud efforts.

The Division was originally established in 1976 to investigate auto liability claims, and has since been expanded to investigate all types of claims. The Division investigators are sworn officers, and insurance companies are required to report suspected fraud to the Division. Over the past several years, the Division has put forth significant efforts to combat PIP fraud by establishing dedicated squads in several areas around the state.

The estimate of the potential savings from the Strike Force will have a high degree of uncertainty because the funding and activities of the Strike Force are yet unknown. The discussion herein assumes that the Strike Force will be funded and that it will also undertake significant anti-fraud efforts. We have no reason to believe that the ultimate activity of the Strike Force will not be significant; however, we have no way of knowing how long it will take the Strike Force to get up and running at a significant level.

In order to determine the potential savings from the Strike Force and other fraud related elements

from HB 119, we have undertaken the following: discussion with the Division regarding current anti-fraud efforts in place and the anticipated impact of the Strike Force; review of PIP anti-fraud efforts in other states; discussions with insurance companies regarding their view of the Strike Force effectiveness; and, review of anti-fraud efforts and statistics in other states. The goal of the analysis is to determine the additional impact of the legislation over and above the efforts already in place in Florida.

a. Discussion with the Division Regarding Current Anti-Fraud Efforts in Place and the Anticipated Impact of the Strike Force

Pinnacle discussed with the Division the existing fraud efforts in Florida focused on PIP fraud, and the expected impact of the Strike Force and other aspects of HB 119 on this effort. The Division currently investigates and prosecutes all types of insurance fraud in Florida, including PIP fraud. Specifically, dedicated squads have been established to focus exclusively on PIP fraud, and these squads have been placed in several areas around the state that have significant problems with insurance fraud. Currently, the Division receives insurance fraud reports and tips from consumers, insurance companies, and insurance professionals. In addition, the Division publishes a monthly newsletter, "*The PIP Source*," outlining the results of anti-fraud efforts specifically related to PIP.

As can been seen on the Division's website, www.myfloridacfo.com/fraud, there are and continue to be significant anti-fraud efforts by the Division specifically related to PIP. It is anticipated that after the creation of the Strike Force, since it is a Direct Support Organization, many of the same anti-fraud efforts will continue to be carried out by the Division. While the Strike Force has been established by HB 119, the funding and activities of the Strike Force are still being discussed and developed. However, it is anticipated that the Strike Force will operate in a manner similar to the Medicare Strike Force established in Florida in 2010. To the extent this is true, the Division believes that the biggest benefits of the Strike

Force will be additional resources that can be used to increase fraud fighting efforts (i.e., hiring additional investigators, prosecutors, etc.), an expanded discussion with other stakeholders on the trends in fraud and the potential future direction of fraud, and coordination of anti-fraud efforts among different government agencies and divisions.

Based on our discussion with the Division, the establishment of the Strike Force is a positive development and will have a positive impact on insurance costs in the long run. However, it will take time for the Strike Force to be funded, for the activities of the Strike Force to get up and running, and for the impacts of the Strike Force's activities to be realized.

b. Review of PIP Anti-Fraud Efforts in Other States

We have also reviewed the anti-fraud efforts in three additional states with PIP coverage. These states were Massachusetts, New York, and New Jersey.

The Massachusetts Insurance Fraud Bureau (MA IFB) was authorized by statute in 1990 and was formed in 1991. It has the authority to investigate fraud in all lines of insurance, but focuses primarily on auto and workers' compensation. The MA IFB has the authority to investigate and analyze insurance fraud, and also works with local law enforcement and prosecutors to accomplish their mission. Since 1991, the MA IFB has been responsible for over 1,000 individuals being charged or indicted with insurance fraud, and this has led to over 500 convictions. While this has had a positive impact on insurance costs, there has been no direct estimate on the overall impact of the fraud efforts on the cost of insurance since the MA IFB has been on operation.

However, near the end of 2003, an intense fraud effort began in Lawrence County that targeted auto insurance fraud, specifically staged accidents. This was an effort that involved cooperation between law enforcement, medical providers, the

general public, and the media to identify and root out auto insurance fraud. Once the efforts in Lawrence County were proven to be successful, similar anti-fraud efforts were rolled out around different high-fraud areas in the state. In 2007, it was estimated that insurance costs had decreased by a statewide average of 11.7%[1]. While it cannot be determined that anti-fraud efforts were the sole reason for this drop in insurance costs, it certainly was part of the driving force of the decrease in costs. Also, the drop in costs varied significantly in different areas of the state, and was estimated to be as high as 24% for Lawrence County.

In New York, the Insurance Frauds Bureau (NY IFB) was created in 1981. It is responsible for detecting and investigating insurance fraud and referring persons that commit fraud for prosecution. The NY IFB receives fraud referrals from licensed insurance professionals, consumers, and anonymous tips. The NY IFB then investigates these referrals, and works with law enforcement and prosecutors in making arrests and prosecuting criminals. In 2011, it was estimated that insurers realized savings of $366,000 for all lines of insurance combined. This results in a negligible premium savings estimate when compared to total premiums written for all lines of insurance in New York. [2]

In New Jersey, the Automobile Insurance Cost Reduction Act of 1998 created the Office of the Insurance Fraud Prosecutor (OIFP). The mission of the OIFP is to investigate and prosecute insurance fraud, and also to serve as the focal point for coordinating anti-fraud activities statewide. This coordination involves state and local departments and agencies. From 1999 to 2010, the OIFP produced annual reports. In these reports, there were descriptions of the activities undertaken by the OIFP and statistics regarding the number of criminals prosecuted and the amount of fines and restitution paid, but no direct measure of savings to insurance companies was reported.

[1] Mohl, Bruce. "Auto Fraud Fight Sends Insurance Rates Down in MA." The Boston Globe. January 25, 2007.
[2] "New York State Department of Financial Services Financial Frauds and Consumer Protection Division Report." March 15, 2012.

c. Discussions with Insurance Companies Regarding Their View of the Strike Force Effectiveness

Insurance companies that were interviewed appear to be optimistic about the potential effectiveness of the Strike Force. One insurer saw three main benefits, including increased identification of fraud cases, increased public awareness, and a potential unbiased voice for future law changes. It is anticipated that the effects of the Strike Force will be more significant as the infrastructure is established, and also as the funding and activity level is better defined. The consistent sense was that there is a belief that the task force will be able to help, but that it is too early to tell what the true impact will be.

d. Review of Anti-Fraud Statistics in Other States

As discussed above, Massachusetts, New Jersey, and New York are states that offer no-fault coverage that have all implemented anti-fraud efforts. As described above, the anti-fraud efforts have been varied, but the efforts described above all fall within the defined scope of the Strike Force. Therefore, as another estimate of potential savings of the Strike Force, we have reviewed the IRC data for Florida as compared to the other states mentioned.

In the IRC data, there is a data field called ‘SIU referral.’ For a specific claim, this field indicates whether or not a claim was referred to the insurance company’s Special Investigative Unit (SIU). There is also a field called ‘SIU result,’ which identifies the outcome of the SIU investigation. Specifically, it indicates whether there was no change made to the claim, whether the claim was somehow compromised, or whether the result was unknown.

Ultimately, the effect of the Strike Force will be measured in claim cost savings at the company level. Given that the anti-fraud efforts have been substantially

underway in all these states for a number of years, we would expect that the results would show up in the SIU and fraud results for the companies. Specifically, if the anti-fraud efforts have been effective at deterring fraud, then lower instances of fraud should be prevail in the claim survey data. Specifically, the instances of SIU results that show a compromised claim should be lower for the other PIP states. This lower instance of compromised claims can give some indication of the potential savings that could be achieved in Florida.

In the table below, we show the total number of claims, the claims referred to the SIU, and the compromised claims for Florida, New Jersey, New York, and Massachusetts.

State	Total Number of Claims	Claims Referred to SIU	Compromised Claims	Compromised /Referred	Compromised/Total
Florida	1,312	47	25	53.2%	1.9%
New Jersey	789	31	8	25.8%	1.0%
New York	1,010	44	9	20.5%	0.9%
Massachusetts	610	17	4	23.5%	0.7%

As can be seen from this table, the percentage of compromised claims as identified by the SIU as a percentage of the total number of claims is 1.9% in Florida, and ranges from 0.7% - 1.0% in the other states. Therefore, this would indicate there is a potential for further reduction in suspicious claim activity of 0.9% - 1.2%. Again, as indicated above, this estimate would be dependent on the additional level of anti-fraud activity in Florida, and these benefits could also take several years to begin to be realized.

Conclusion

As can be seen from the discussion of current and expected anti-fraud efforts and the analysis of anti-fraud efforts in other PIP states, the range of potential impact is 0 – 11.7%. The upper end of this range is based on estimates from specific fraud efforts that were undertaken twelve years after the MA IFB was created. In addition, as discussed earlier, there are already PIP anti-fraud efforts underway in Florida, and the estimated savings will have to take into account these efforts. Given that the funding and the specific activities of the Strike Force are yet to be finalized, we cannot provide a definitive estimate of the savings that could be achieved as a result of the Strike Force. The 0 – 11.7% is thus illustrative of what can be achieved in the long term once anti-fraud efforts take hold.

For the purposes of this report, we have been asked to estimate the impact of the Strike Force over the next two years on PIP loss costs. Given the discussion above and based on the fact that the Strike Force is still developing, we anticipate that the expected savings over the next one to two years is 0.5% – 2.0 %. We would expect that the savings would be closer to the higher end of the range by year two as the additional anti-fraud efforts are ramped up.

4. Separation of Death Benefit (Lines 668-669 & 777-781)

Under the current law, the death benefit under PIP was the lesser of the unused PIP benefits and $5,000. The new law provides $5,000 in death benefits in addition to the $10,000 in medical and disability benefits.

Exhibit 4, page 1 displays the percentage of Florida fatalities per automobile accident during the last 5 years based on data from the Florida Highway Safety and Motor Vehicle Crash Statistics reports.

In Exhibit 4, page 3 we apply these fatality rates to the closed claims from the OIR Report and multiply by the new death benefit of $5,000 to get the estimated increase in PIP benefits which

would have been paid if the $5,000 death benefit had been in effect during the period 2006 – 2010. This increase is then reduced by the average death benefit currently being paid under PIP coverage. This produces the estimated increase in PIP benefits due to the separation of the death benefit. Based on our calculations, we estimate that the separation of the death benefit will result in an increase of 0.6 – 0.8% in overall PIP costs.

5. Initial Services within 14 Days (Lines 677-679)

The bill revises the provision of Personal Injury Protection medical benefits under the Florida Motor Vehicle No-Fault Law, effective January 1, 2013. Individuals seeking PIP medical benefits are required to receive initial services and care within 14 days after the motor vehicle accident. Initial services and care are only reimbursable if lawfully provided, supervised, ordered or prescribed by a licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. Follow up services and care require a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.

Based on data provided by the Insurance Research Council the percentage of claimants seeking medical treatments within 14 days has been increasing. It was 77% in 2005 and has increased to 90% in 2007 (See Exhibit 5). The average cost per claim shows little difference between claimants seeking medical treatments within 14 days and those who wait.

	All Claims		Initial Treatment <=14 Days Claims			
Accident Year	Number of Claims	Total Paid	Number of Claims	Total Paid	Percentage of Claims	Percentage of Loss
(1)	(2)	(3)	(4)	(5)	(6)	(7)
N/A	13	54,076	0	0	0.0%	0.0%
1997	1	13,719	1	13,719	100.0%	100.0%
1998	1	12,950	0	0	0.0%	0.0%
1999	1	11,505	0	0	0.0%	0.0%
2000	3	29,280	2	24,080	66.7%	82.2%
2001	4	24,020	3	21,845	75.0%	90.9%
2002	5	37,556	3	19,456	60.0%	51.8%
2003	8	55,270	7	46,146	87.5%	83.5%
2004	30	168,508	26	140,854	86.7%	83.6%
2005	128	970,269	99	766,648	77.3%	79.0%
2006	595	3,973,149	495	3,320,647	83.2%	83.6%
2007	570	3,179,355	513	2,814,819	90.0%	88.5%
2005-2007	1,293	8,122,773	1,107	6,902,114	85.6%	85.0%

As the majority of claimants will be aware that they must seek treatment within 14 days, this change to the PIP requirement will not necessarily eliminate all claims with initial visits after 14 days. It may also cause some claimants with minor injuries to seek treatment immediately rather than waiting and seeing if treatment was necessary. The IRC data indicates that 15% of losses are from claims where the claimant did not seek treatment within 14 days. We conclude that the impact from requiring treatment within 14 days indicates a possibility of savings of up to 1.5%. (We assume 10% of the claimants who delayed treatment will be removed from the PIP system and a lower bound on the savings from this source of 0 %.)

6. Limitation on Non-Emergency Conditions (Lines l750-754)

The bill applies two different coverage limits for PIP medical benefits, based upon the severity of the initial medical condition of the individual. An individual may receive up to $10,000 in medical benefits for services and care if a physician, osteopathic physician, dentist, physician's assistant or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition. An emergency medical condition is defined as a medical

condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part. For an individual who is not diagnosed with an emergency medical condition, the PIP medical benefit limit is $2,500.

The new definition of emergency medical care tracks very closely with the federal statute 42 USC 1395dd(a) of Federal law and Section 1867A of the Social Security Act. It also parallels Section 395.002, of the Florida statutes dealing with the definition of emergency care. Legal questions have arisen as to whether the federal case law regarding the definition will be applicable to the definition contained in HB 119.

In order to determine which claims are non-emergency under this definition and therefore limited to $2,500, Pinnacle used the IRC data base trended to 2012 and removed all claims that included emergency room treatment based on the assumption that these claims would be considered emergency medical care under the new statute. Of the remaining claims, we additionally separated the claims into “emergency” and “non-emergency” based on whether or not the claim met the tort threshold based upon the claims handler’s opinion. The assumption here is that the verbal threshold is a good indication of whether or not the injury was serious and therefore would likely meet the definition of “emergency”. To bring the IRC claims to today’s level we applied an 8% annual cost trend to both the “emergency” and “non-emergency” claims (but capped at $10,000 per claim for emergency and $2500 per claim for non-emergency claims) and an increase in the number of non-emergency claims since 1997 of 10%, and an increase in the number of emergency claims of 1.5%. These frequency trends produce an overall increase in PIP frequency of 3.5 - 4% which approximates the increase in PIP claims relative to PD claims since 2007 as measured by Fast Track. We have assumed that 75% of the increase in PIP claim frequency would be from “non-emergencies” since they are not the result of increased accidents as measured by PD claim frequency.

Emergency room medical payments and the additional “emergency” claims as described above accounted for 70% of all medical payments. Therefore, 30% of medical payments would be

considered non-emergencies. Only 3.3% of non-emergency claims are less than the $2,500 threshold. The distribution by size of loss is shown below.

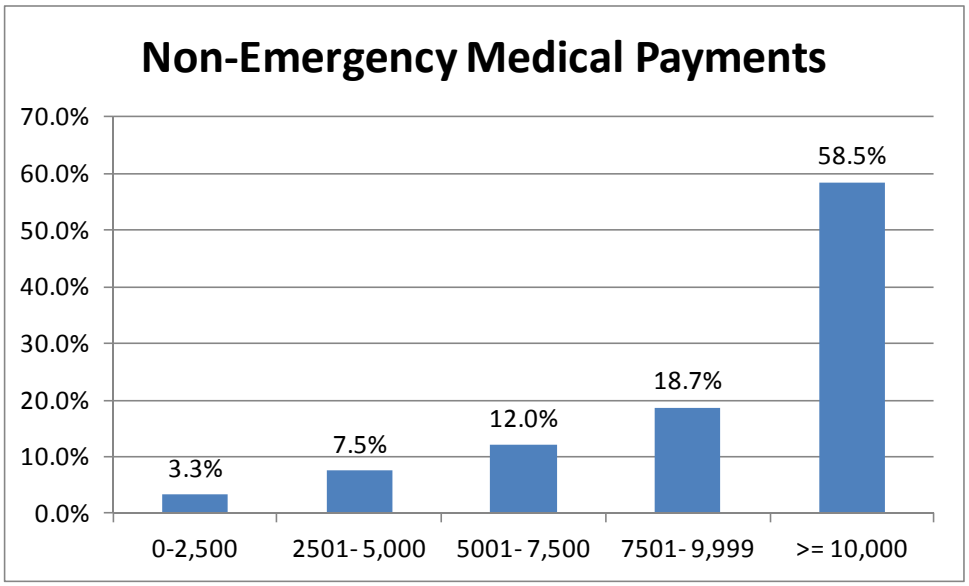


Exhibit 6 provides the data underlying this graph. Also shown in Exhibit 6 are the capped non-emergency medical payments. Although the definition of emergency medical claims is similar to the definition in federal statutes, it is expected that claimants may challenge a non-emergency determination. Also, it has been observed that health care entities are already advertising to provide services to document that an injury meets the definition of an emergency. The Consumer Advocate's office recommends that the Office of Insurance Regulation should provide an Advisory Opinion on what constitutes an emergency medical condition to reduce the challenges to a non-emergency determination and provide guidance to insurers. However it is not clear that the OIR has the authority to issue such an Advisory Opinion.

We conclude that the savings from the limitation on non-emergency conditions would indicate a possibility of savings of approximately 10-15% (1/2 to 3/4 of indicated) range.

7. Exclusion of Massage Therapy & Acupuncture (Lines 755-776)

Massage and acupuncture are not reimbursable under HB 119, regardless of the type of provider rendering such services. As shown in Exhibit 7, based on data from Mitchell, we have estimated

the amount of current PIP payments which are attributable to massage as defined in s. 480.033 or acupuncture as defined in s. 457.102. We have identified massage benefits as CPT code 97124 and acupuncture as CPT codes 97810, 97811, 97813, and 97814. We also reviewed other procedures performed by massage therapists and included an estimated savings for these since the law precludes all services provided by licensed massage therapists from recovery under PIP. Based on these codes and the estimated additional procedures provided by massage therapists, we estimate the maximum potential savings as 13.9%. In our claims interviews there is considerable concern by insurers and others that some of the massage benefits currently being paid under PIP may be coded to other CPT codes providing physical therapy.

In this connection, we have reviewed data from Mitchell, Inc. which indicates that there has been a significant decline in the percentage of units charged for chiropractic CPT Codes 98940, 98941 and 98942 (Chiropractic manipulation) during the last four years. At the same time, data shows that there has been a significant increase in massage therapy code 97124. It is speculated that this could be evidence of coding the manipulation as massage therapy in order to obtain larger fees. If this is true, this would indicate a possibility that some of the massage therapy treatment going forward will return to the Chiropractic manipulation codes.

In any event, our best judgment is that not all of the payments currently being coded as massage therapy will be eliminated from the system and there will be "leakage" due to recoding of the treatments previously coded as massage therapy which we have recognized by adopting an indicated savings of 7 – 10% (approximately ½ to ¾ of indicated).

8. Repay Medicaid within 30 Days (Lines 821-823)

The new law adds language which states that "However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program."

In theory, this change has the potential to increase costs of PIP coverage in Florida. However, it is our understanding that the providers in Florida generally go to the PIP insurers first and that

even if Medicaid pays first, the insurers are repaying Medicaid today, so we believe that any increase in costs from this change is negligible.

9. Submission of Revised Claim within 15 Days (Lines 852-860)

Changes are made to the statutory process for the payment of PIP benefits, primarily to assist claimants in their claim submissions, effective January 1, 2013. A claimant whose claim is denied due to an error in the claim is given 15 additional days to correct the erroneous claim and resubmit it timely. The insurer must maintain a log of all PIP benefits paid on behalf of the insured and must provide the log to the insured upon his or her request if litigation has initiated. If a dispute between an insurer and claimant occurs, the insurer must provide notice within 15 days of the exhaustion of PIP benefits.

We do not believe that these provisions will significantly save or increase PIP costs.

10. Additional 60 Days for Fraud Investigation (Lines 964-975)

Under HB 119, if an insurance company has a reasonable belief that a claim is fraudulent, within 30 days of being notified of the claim the insurer can notify the claimant that the claim is being investigated for fraud. Once this notification has been made, the insurer then has an additional 60 days to investigate the claim beyond the initial 30 days. If it is ultimately deemed that the claim should be paid, simple interest must be paid by the insurance company to the claimant from the date that notification was made to the insurer to the date of payment.

This provision would have a potential impact on insurance costs if insurers were not able to adequately investigate claims within the current 30 day period, or if there were claims that an insurance company suspected were suspicious but due to the limited time period decided just to pay them because the workload of the SIU.

Based on our discussion with insurance companies and our understanding of their procedures today, we estimate that the savings from this provision will be negligible. Insurers indicated that

they were able to handle the claim investigation within the current 30 day period, so the additional 60 days would not be of any additional benefit. Also, because of the added potential of 60 days of interest, any potential savings would be offset by the additional interest that is due on the claims that are ultimately paid.

11. Report All Claims Denied for Fraud to Division of Insurance Fraud (Lines 975-977)

If a claim is denied by an insurance company for fraud, the claim must be reported to the Division of Insurance Fraud.

We expect this provision of HB 119 to have a negligible impact. Based on the insurance companies that we interviewed, fraudulent claims are currently being reported to the Division of Insurance Fraud, so this will not be a new practice.

12. Fix Medicare Fee Schedule (Lines 1049-1057)

Since 2001 there have been numerous attempts to limit PIP claims through the use of a Medical Fee Schedule. In 2001, the Florida Legislature enacted a fee schedule for a narrow class of PIP claims.

Several years later the Legislature concluded that a fee schedule for only a narrow class of PIP claims was insufficient to drive down the costs of PIP. In a report commissioned in 2005 and prepared for the Florida Senate by the Committee on Banking and Insurance[3], the Committee found that "[p]remium rates for PIP increased significantly from 2002 to 2003," and that this increase was attributable to an "increased amount paid for the average PIP claim.[i]"

The Committee recommended that the Florida Legislature:

[3] Comm. on Banking & Ins., Florida's Motor Vehicle No-Fault Law, Report No. 2006-102 at 62 (2005).

1. Reenact the no fault law provided that additional reforms are enacted to control costs, most importantly, a medical fee schedule as listed below.
2. Adopt a medical fee schedule for PIP, set at a specified percentage above the Medicare fee schedule. In addition to helping control PIP medical costs, a fee schedule would also reduce litigation over the reasonableness of medical fees and thereby reduce PIP loss adjustment expenses and attorney fee awards by insurers.

In 2007, based on the Committee's report and recommendations, the Florida Legislature enacted a fee schedule for all PIP claims.[4](stating that the reenactment of the No-Fault Law and the creation of the PIP fee schedule "was intended to be remedial and curative in nature"). The PIP statute requires insurers to pay "[e]ighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services." § 627.736(1)(a). The 2007 revision amended the PIP statute to incorporate Medicare fee schedules. Section 627.736(5)(a)(2)(f) provides that an insurer may limit reimbursement to providers to 80 percent of "200 percent of the allowable amount under the participating physicians schedule of Medicare Part B."

However, in the marketplace, some insurers who implemented this change were later precluded from utilization of the fee schedules because of several adverse court decisions[5]. Specifically these cases cited the permissive nature of the revised statute which indicated that insurers "**may"** use the limitations to the Medicare schedule as cited in the statute and the fact that the company's policies also indicate that the company will pay 80% of medical expenses," defining "medical expenses" as "reasonable expenses for necessary medical, surgical, [and] X-ray . . . services."

Accordingly, these decisions give the insured the benefit of the doubt given two methods are prescribed and thus required that the higher of the two methods be paid to the insured.

[4] See Ch. 2007-324, § 19, Laws of Fla. (2007)
[5] Kingsway Amigo Insurance Company v. Ocean Health, Inc.; GEICO Indemnity Company v. Virtual Imaging Services, Inc.

The Personal Insurance Federation of Florida responded to our claim interview with "The fee schedule changes that went into effect in 2008 led to an unexpected deluge of lawsuits related to their application and to the "reasonableness" of the amount paid by the carriers under the applicable fee schedule. Generally speaking, this is an industry-wide phenomenon."

We would note that under HB 119, effective July 1, 2012, an insurer may limit payments for the Medicare fee schedule only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payments pursuant to the schedule of changes specified in the law.

Based on the results of our claim survey and discussions with Mitchell, Inc. most carriers have already implemented a medical fee schedule. Those carriers that have already implemented a medical fee schedule and filed the OIR policy form will see little impact from HB 119. The remaining carriers should see a savings as discussed below.

Mitchell, Inc. provided PIP medical loss data for "total charged" and "Fee Schedule Adjustment" by year for 2004 – 2011 (See Exhibit 8). Mitchell, Inc. believes that 90% of the PIP claims they review currently have a Medicare fee schedule in place.

Exhibit 8 shows that the savings from the medical fee schedule from Mitchell data for 2011 would indicate a possibility of savings of approximately 29% from using the Medical Fee Schedule with most of the Medicare protocols (Outpatient Prospective Payment System, Inpatient Prospective Payment System, Multiple Procedure Payment Reduction and National Correct Coding Initiative) turned off. We also examined the Fast Track Florida average paid claim costs for 2008 (the year after Medicare fee schedules were implemented by most carriers in Florida). This data shows average paid PIP claim costs showed no significant reduction in 2008 which would indicate a savings of approximately 0 % for implementing the Medicare Fee Schedule.

We have assumed a 0% savings for the minimum impact and a 1.5% for the maximum impact (average of 0% for 90% of PIP claims and 15% for 10% of PIP claims). The 15% is an average of the impact based on Fast Track data (0%) and the impact based on Mitchell data (29%).

13. Insureds Must Comply with Policy Conditions/Examination Under Oath (Lines 1428-1439)

It should be noted here that the right to require an examination under oath can be included in policy contracts for automobile insurance today. Therefore, it is our finding that having the statute explicitly allow for these types of examinations when included in the policy contract is not expected to produce any significant savings.

14. Insureds Refusal to Submit or/Failure to Appear at Two Medical Exams (Lines 1522-1525)

This section of the new law provides that if a person unreasonably refuses to submit to or fails to appear at an independent medical examination (IME), the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

We would note that this change should address the case law in *Custer Medical Center v. United Automobile Insurance Co.* and generally relieves insurers in these cases of liability for PIP payments. We would also note that the ability of insurers to refer questionable claims for medical services to a Peer Review Organization (PRO) was believed to be a factor in the success of the Pennsylvania no fault reform law (Act 6). While the IME is not the same as a PRO, it has the potential to produce similar positive effects in denying unnecessary or fraudulent treatment.

We have examined the IRC data for claims which had been identified by the claims person as "refused IME". This coding does not indicate whether the claimant's refusal to submit to am IME or failure to appear at the IME occurred once or more than once. However the number of

such claims was small, just 0.9% of all PIP claims. It is likely that the number who refused to appear at two IME's would be even smaller. In addition it is likely that if the insureds become aware that a refusal or failure to appear at two IME's may result in loss of PIP benefits, this number would become smaller yet. We examined the dollars paid on these claims in the IRC data base and noted that it was more significant (approximately 12%). We have applied a 10% likelihood of a refusal to submit or failure to appear two times for an IME which is held as unreasonable by the judge as the high end savings and estimated an overall savings of 0.6 – 1.2%.

15. Attorney Fees Calculated w/o Contingency Fee Multiplier (Lines 1543-1545)

HB 119 **requires** that **"**Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

Per the 2011 PIP Working Group Report:

> "Currently, cases involving PIP litigation are subject to the award of a contingency Risk Multiplier. *Compensation Fund v. Rowe* established the precedent that courts could use a contingency risk multiplier in calculating the attorneys' fees awarded pursuant to a "fee-shifting" statute. However, in a later decision, *Sarkis v. Allstate Insurance Company,* the Court acknowledged it never intended to vest trial or appellate courts with the ability to apply attorneys' fees in statutes that impose "penalties" on parties who do not prevail in litigation. The Court has refused jurisdiction from certified questions from the Third and Fifth District Court of Appeals regarding the application of the multiplier for attorneys' fees resulting from penalty based fee statutes. The result has been conflicting decisions in the Fifth and First District Courts of Appeals. The main controversy in these cases involves the essential requirements found in Rowe that one of the underpinnings for the award of the multiplier would be that it is established that the relevant market requires a contingency fee multiplier to obtain competent counsel. It is noted in the Fifth Districts' case *Progressive Express Insurance Co. v Shultz* the Court noted that "[c]ommon sense also plays a role here. We are not so isolated from the world around us to know that few people have any difficulty retaining competent counsel in these circumstances. Our

> docket, and the dockets of the trial courts in Central Florida, has hundreds, and perhaps thousands, of PIP suits pending at any given time." In addition to capturing the increased frequency of lawsuits, a request for information regarding any change in severity was made of the insurance industry. Based on information from a survey conducted by the Property Casualty Insurers Association of America (PCI) and Personal Insurance Federation of Florida (PIFF), from 2008 through the third quarter of 2011, total attorneys' fees have represented approximately 5 percent of total No-Fault losses and loss adjustment expenses (LAE). Between 2009 and 2011, the amounts paid to plaintiff attorneys have grown nearly three times faster than amounts paid to defense attorneys, which is offered to support the insurers' position that they currently allocate more resources towards the increasing number of No-Fault lawsuits. However, data from the industry does not support that the development of attorneys' fees represents an increase of severity. The attorneys' fees impact has been the result of frequency in the number of demands and suits filed and the perpetuation of these settlements with attorneys' fees awarded consistently over hundreds of lawsuits where the underlying claim may be pennies on the dollar. Information from Farmers Insurance Company submitted to the House of Representatives Insurance & Banking Subcommittee revealed a case study example of one global settlement with one provider represented by one attorney for over 300 cases. The underlying indemnity to the provider was $69,694 while the attorney received over $890,000 in fees for the global settlement."

We have attempted to verify the use of a contingency fee multiplier by district in our claim interviews. It is our understanding that multipliers have been allowed in Escambia County and the First DCA in Florida pursuant to *Massie v. Progressive Express.* This case contradicts *Progressive v. Schultz.* Our understanding is that the *Massie* case requires a showing that a party would have difficulty securing counsel without the opportunity for a multiplier. This implies that it did not apply to all PIP cases in the First District, but only to cases with an affirmative showing that they would have had difficulty in securing counsel without the use of contingency multipliers. Our discussions with company claim representatives indicate that only a minority of cases outside Escambia County have involved multipliers. To arrive at our estimate, we determined the percentage of the claims in Florida that came from Escambia County and added 10% of the PIP medical payments from the remainder of the counties in the first DCA as the assumed number of cases which have successfully obtained multipliers. We then multiplied this percentage times the estimated 5% of PIP payments that went to attorney fees cited above from the study by PCI and PIF times a 2.5 multiplier to arrive at an estimated savings from elimination of the multiplier of 0.2%. (See Exhibit 10).

16. Loss of License to Practice for 5 Years/Reimbursement for PIP 10 Years (Lines 1746-1751)

A licensed healthcare practitioner who is found guilty of fraud under this statute will lose their license to practice for five years and will not be eligible to receive PIP reimbursements for ten years.

The impact of this provision will be dependent on its enforcement and the effect of this enforcement to deter medical providers from involvement in fraudulent schemes due to the potential loss of license to practice. The impact of this provision, at least initially, is difficult to put an estimate on. There certainly is the potential for a positive impact if the loss of license becomes a very real possibility, but given the small number of prosecutions and convictions of healthcare providers for fraud, it would be difficult to predict a significant impact without increased levels of convictions. Below are shown the number of convictions of providers for Personal Injury Protection fraud based on the Florida Fraud Division statistics since 2004:

Fiscal Year	Provider Convictions
2004/2005	21
2005/2006	18
2006/2007	16
2007/2008	24
2008/2009	11
2009/2010	25
2010/2011	35

The number of providers convicted yearly has fluctuated, but has been as low as 11 and as high as 35 for the last year that data is available. So the actual percentage of providers being convicted is a small number of total providers, and is even a small percentage of the number of cases referred to the Division of Insurance Fraud.

Currently, the penalties for fraud are significant, so to the extent that the current penalties are a deterrent to providers for committing insurance fraud, the addition of a five year loss of license and a 10 year loss of the privilege for PIP reimbursement will not be likely to provide an

additional deterrent. Currently, medical providers convicted of insurance fraud face prison time, fines, and restitution. Depending on the extent of the fraud, the prison time can be significant, and certainly greater than 10 years. Therefore, to the extent that a significant prison sentence is not a deterrent, the proposed penalties will not be an additional deterrent.

Given this, we estimate that the medical provider loss of license penalties and loss of the right to receive PIP reimbursements for 10 years will have a negligible impact of PIP costs in Florida.

Bodily Injury/Uninsured/Underinsured Motorists Coverage

It should be noted that injured accident victims in Florida whose medical bills are not paid by the PIP benefit can sue for excess economic loss benefits. They can additionally sue for "pain and suffering" if the injuries meet the verbal threshold criteria in Florida law. Therefore, the reduction in PIP benefits due to HB 119 will likely result in an increase in BI costs. This increase in costs will not be one-for-one since the insured's recoveries under BI or UM/UIM will be reduced by their percentage of fault under Florida's comparative negligence law.

As shown on the attached Exhibit 2 our estimate of the corresponding increase in BI/UM/UIM premiums is +3.0% to 4.7%.

Claim Surveys

As part of our study, we surveyed a sampling of the major writers of automobile insurance in Florida. The survey form is attached as Exhibit 12 and was conducted through phone interviews. A summary of the survey responses is part of Exhibit 12.

The purpose of the claims interviews was to zero in on what the carriers believed the issues would be in implementing HB 119 and to secure their perceptions on the financial impact of the PIP changes. While much of each interview was seeking qualitative responses, we also sought quantitative data as well. Ten companies were contacted for input. Six companies responded.

Their responses are included in Exhibit 12, listed as Insurers 1 through 6. We also received a written response from the PIFF which has been included in the survey results.

Most carriers were reluctant to share raw data, although a few did report their data through the Personal Insurance Federation of Florida (PIFF). The PIFF aggregated numerical data before providing it to Pinnacle, as well as most of the qualitative responses as shown in Exhibit 12.

Overall the companies were not expecting much in the way of savings from HB 119, or at best, were uncertain of what to expect. We also held several discussions with the Florida Consumer Advocate, Robin Westcott and her staff and went through the claim survey with her to get her opinions and advice on various provisions of HB 119. We are grateful for her time and valuable comments as we are to all of the insurers who agreed to be interviewed or provided data to us. We also want to thank Mitchell, International for their data and insights.

Commercial Automobile

Certain commercial automobiles and others are required to carry PIP coverage as well as personal automobiles. The savings from HB 119 shown in this report would generally apply to these vehicles as well.

INDEX OF EXHIBITS

Florida Office of Insurance Regulation Exhibit 1

Analysis of Florida HB119

Anticipated Income Effects

Item #	Item Description	Lines	Minimum Impact	Central Impact	Maximum Impact
1	Expansion of Florida Traffic Crash Report Long Form	130-154	0.0%	-0.8%	-1.5%
2	Clinics must be Licensed	331-334	0.0%	0.0%	0.0%
3	Establish Automobile Insurance Fraud Strike Force	478-613	-0.5%	-1.3%	-2.0%
4	Separation of Death Benefit	668-669 & 777-781	0.6%	0.7%	0.8%
5	Initial Services within 14 Days	677-679	0.0%	-0.8%	-1.5%
6	Limitation on Non-Emergency Conditions	750-754	-9.8%	-12.3%	-14.7%
7	Exclusion of Massage Therapy & Acupuncture	755-776	-6.9%	-8.7%	-10.4%
8	Repay Medicaid within 30 Days	821-823	0.0%	0.0%	0.0%
9	Submission of Revised Claim within 15 Days	852-860	0.0%	0.0%	0.0%
10	Additional 60 Days for Fraud Investigation	964-975	0.0%	0.0%	0.0%
11	Report All Claims Denied for Fraud to Division of Insurance Fraud	975-977	0.0%	0.0%	0.0%
12	Fix Medicare Fee Schedule	1049-1057	0.0%	-0.8%	-1.5%
13	Insureds Must Comply with Policy Conditions/Examination Under Oath	1428-1439	0.0%	0.0%	0.0%
14	Insureds Refusal to Submit/Failure to Appear at 2 Medical Exams	1522-1525	-0.6%	-0.9%	-1.2%
15	Attorney Fees Calculated w/o Contingency Fee Multiplier	1543-1545	-0.2%	-0.2%	-0.2%
16	Loss of License to Practice for 5 Years/Reimbursement for PIP 10 Years	1746-1751	0.0%	0.0%	0.0%
(1)	Adjustment for Overlap		1.1%	2.4%	3.5%
(2)	Overall Anticipated Impact on Losses		-16.3%	-22.7%	-28.7%
(3)	General and Other Acquisition Expenses		14.3%	14.3%	14.3%
(4)	PIP Premium Savings		-14.0%	-19.5%	-24.6%

Rows

(1) See Report text for explanation.

(2) Sum of Individual Items + Row (1)

(3) Derived from AM Best 2010 Annual Statement Data

(4) Row (2) x [1 - Row (3)]

Florida Office of Insurance Regulation Exhibit 2

Analysis of Florida HB119

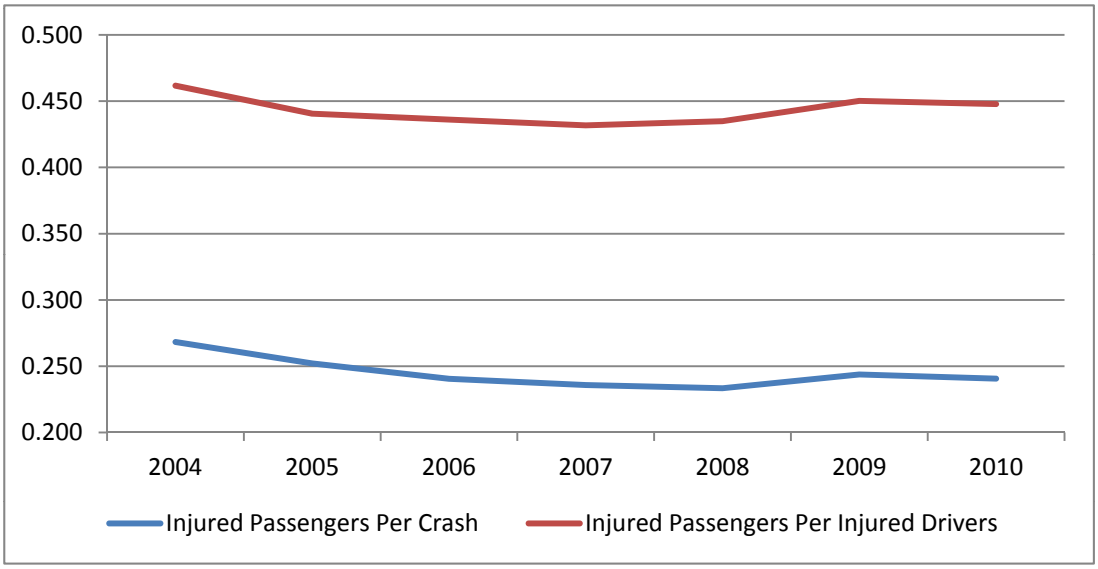
Bodily Injury, Uninsured Motorists and Underinsured Motorists Offset

Item #	Item Description	Minimum Impact	Central Impact	Maximum Impact
(1)	PIP Premium Savings Excluding Fraud	-13.5%	-17.7%	-21.6%
(2)	Lawsuit Recovery for Comparative Negligence	50%	50%	50%
(3)	Percentage of Claims when at least 1 Driver has BI	91.0%	91.0%	91.0%
(4)	Average PIP Premium	209.37	209.37	209.37
(5)	Average BI and UM Premium	432.99	432.99	432.99
(6)	Bodily Injury and Uninsured Motorist Offset	3.0%	3.9%	4.7%

Row	
(1)	Exhibit 1, Row (4) with Fraud Removed
(2)	Judgment
(3)	Derived from NAIC Fast Track Plus Data
(4)	Exhibit 11, Column (22), 2010
(5)	Exhibit 11, Column (20), 2010 + Exhibit 11, Column (24), 2010
(6)	-Row (1) x Row (2) x Row (3) x Row (4) / Row (5)

Expansion of Florida Traffic Crash Report Long Form (lines 130-154)

Year	# of Crash Reports	# of Injured Drivers	# of Injured Passengers	# of Passengers Injured Per Crash	# of Passengers Injured Per Driver Injured
(1)	(2)	(3)	(4)	(5)	(6)
2004	252,902	146,972	67,849	0.268	0.462
2005	268,605	153,724	67,716	0.252	0.441
2006	256,200	141,314	61,619	0.241	0.436
2007	256,206	139,915	60,402	0.236	0.432
2008	243,342	130,599	56,800	0.233	0.435
2009	235,778	127,683	57,479	0.244	0.450
2010	235,461	126,544	56,670	0.241	0.448



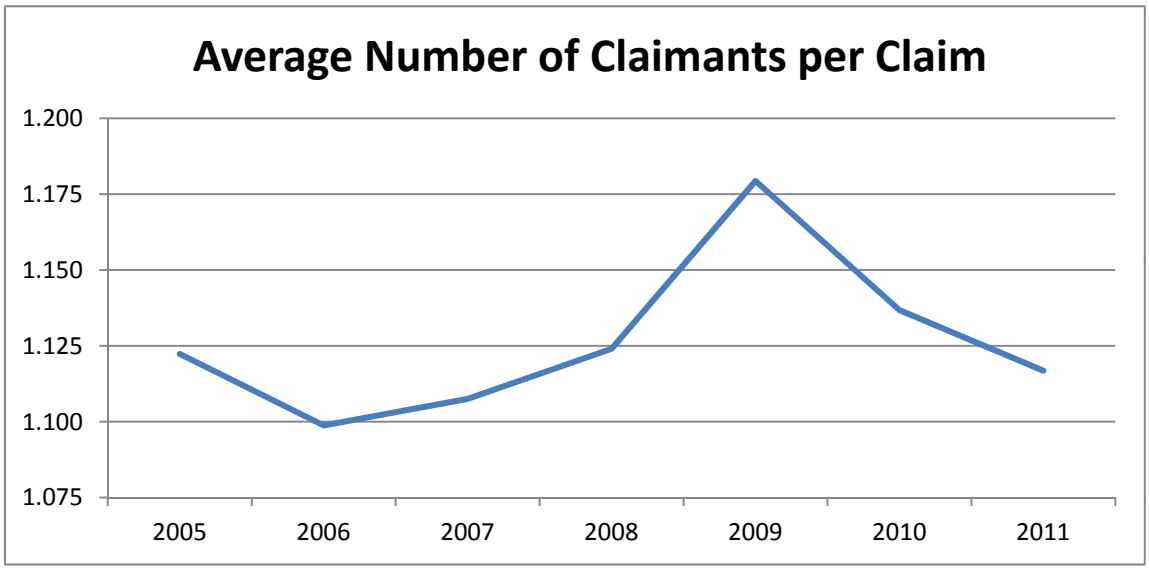
Columns

(2) - (4) Derived from Florida Highway Safety and Motor Vehicles - Traffic Crash Statistics Reports 2004-2010

(5) Column (4) / Column (2)

(6) Column (4) / Column (3)

Year (1)	# of Claimants (2)	# of Claims (3)	Claimants per Claim (4)
2005	229,018	204,053	1.122
2006	222,309	202,320	1.099
2007	216,367	195,362	1.108
2008	224,751	199,949	1.124
2009	192,861	163,530	1.179
2010	272,118	239,375	1.137
2011	230,498	206,389	1.117



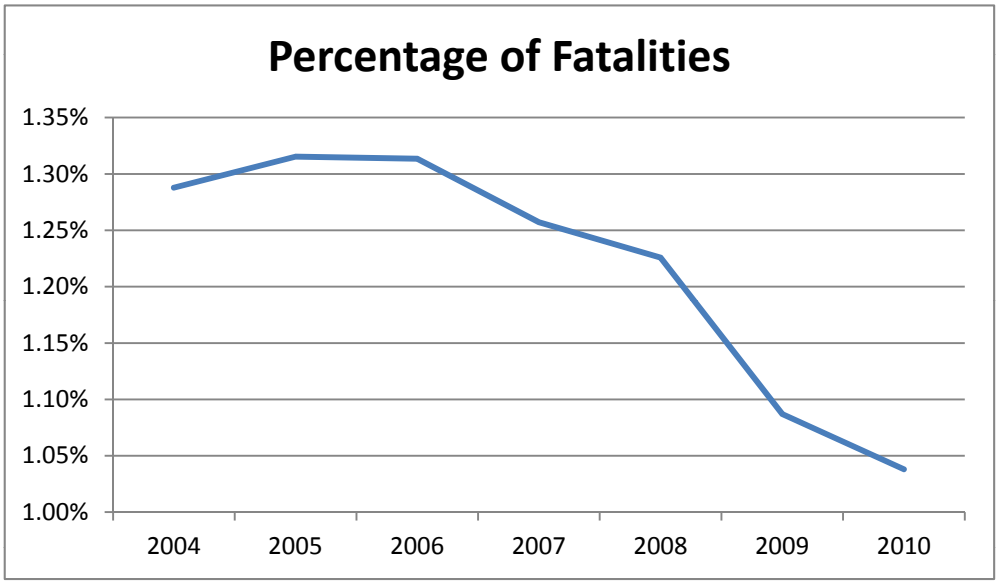
Columns

(2) - (3) PIP Claim Data provided by Mitchell, International

(4) Column (2) / Column (3)

Separation of Death Benefit (lines 668-669 & 777-781)

Year (1)	# of Crash Reports (2)	# of Fatalities (3)	Percentage of Fatalities Per Crash (4)
2004	252,902	3,257	1.29%
2005	268,605	3,533	1.32%
2006	256,200	3,365	1.31%
2007	256,206	3,221	1.26%
2008	243,342	2,983	1.23%
2009	235,778	2,563	1.09%
2010	235,461	2,444	1.04%



Columns

(2) - (3) Derived from Florida Highway Safety and Motor Vehicles - Traffic Crash Statistics Reports 2004-2010

(4) Column (3) / Column (2)

Separation of Death Benefit (lines 668-669 & 777-781)

				Fatality Claims		
Accident Year	Number of Claims	Number of Fatalities	Percentage of Fatalities	Paid Loss Medical	Paid Loss Wage	Paid Loss Other
(1)	(2)	(3)	(4)	(5)	(6)	(7)
N/A	13	0	0.0%	0	0	0
1997	1	0	0.0%	0	0	0
1998	1	0	0.0%	0	0	0
1999	1	0	0.0%	0	0	0
2000	3	0	0.0%	0	0	0
2001	4	0	0.0%	0	0	0
2002	5	0	0.0%	0	0	0
2003	8	0	0.0%	0	0	0
2004	30	0	0.0%	0	0	0
2005	128	0	0.0%	0	0	0
2006	595	4	0.7%	8,695	0	5,000
2007	570	11	1.9%	20,000	0	33,869
2006-2007	1,165	15	1.3%	28,695	0	38,869

Columns

(2) - (3) Insurance Research Council
(4) Column (3) / Column (2)
(5) - (7) Insurance Research Council

Accident Year	Closed Claims w/ Payment	Gross PIP Paid Claims	Current Average PIP Claim Payment	% of Fatalities	Death Benefit	Expected Death Benefit	Current Death Benefit	Change in Death Benefit	Expected Average PIP Claim Payment	% Increase in Avg. PIP Claim
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
2006	176,059	1,211,207,686	6,880	1.31%	5,000	66	11	55	6,935	0.80%
2007	192,901	1,290,228,719	6,689	1.26%	5,000	63	11	52	6,741	0.78%
2008	164,861	1,132,830,827	6,871	1.23%	5,000	61	11	51	6,922	0.74%
2009	207,505	1,598,520,173	7,704	1.09%	5,000	54	11	44	7,747	0.57%
2010	267,830	1,936,451,802	7,230	1.04%	5,000	52	11	41	7,272	0.57%

Columns

(2) - (3) Florida Office of Insurance Regulation, PIP Data Call
(4) Column (3) / Column (2)
(5) Derived from Florida Highway Safety and Motor Vehicles - Traffic Crash Statistics Reports 2004-2010
Shown on Exhibit 4, Page 1, Column (4)
(6) HB 119
(7) Column (5) x Column (6)
(8) Column (6) x 0.21% based on claims surveys
(9) Column (7) - Column (8)
(10) Column (4) + Column (9)
(11) Column (10) / Column (4) - 1

Florida Office of Insurance Regulation Exhibit 5

Analysis of Florida HB119

Initial Services within 14 Days (lines 677-679)

	All Claims		Initial Treatment <=14 Days Claims			
Accident Year	Number of Claims	Total Paid	Number of Claims	Total Paid	Percentage of Claims	Percentage of Loss
(1)	(2)	(3)	(4)	(5)	(6)	(7)
N/A	13	54,076	0	0	0.0%	0.0%
1997	1	13,719	1	13,719	100.0%	100.0%
1998	1	12,950	0	0	0.0%	0.0%
1999	1	11,505	0	0	0.0%	0.0%
2000	3	29,280	2	24,080	66.7%	82.2%
2001	4	24,020	3	21,845	75.0%	90.9%
2002	5	37,556	3	19,456	60.0%	51.8%
2003	8	55,270	7	46,146	87.5%	83.5%
2004	30	168,508	26	140,854	86.7%	83.6%
2005	128	970,269	99	766,648	77.3%	79.0%
2006	595	3,973,149	495	3,320,647	83.2%	83.6%
2007	570	3,179,355	513	2,814,819	90.0%	88.5%
2005-2007	1,293	8,122,773	1,107	6,902,114	85.6%	85.0%

Columns

(2) - (5) Insurance Research Council

(6) Column (4) / Column (2)

(7) Column (5) / Column (3)

Analysis of Florida HB119
Limitation on Non-Emergency Conditions (lines 750-754)
Data has been trended to 2012

					Non-Emergency Medical Payments						Capped Non-Emergency Medical Payments							
Accident Year	Total Payments	Non Medical Payments	Total Medical Payments	Emergency Medical Payments	Total	0-2,500	2,501 - 5,000	5,001 - 7,500	7501 - 9,999	>= 10,000	Total	0-2,500	2,501 - 5,000	5,001 - 7,500	7501 - 9,999	>= 10,000	Total Savings Dollars	Total Savings Percent
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
N/A	57,931	25	57,905	53,681	4,224	1,152	3,072	0	0	0	3,902	1,152	2,750	0	0	0	322	0.6%
1997	11,000	0	11,000	0	11,000	0	0	0	0	11,000	2,750	0	0	0	0	2,750	8,250	75.0%
1998	10,150	0	10,150	10,150	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
1999	10,150	0	10,150	10,150	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
2000	10,444	6,637	3,808	0	3,808	0	3,808	0	0	0	2,750	0	2,750	0	0	0	1,058	10.1%
2001	31,666	0	31,666	10,150	21,516	0	4,937	5,578	0	11,000	8,250	0	2,750	2,750	0	2,750	13,266	41.9%
2002	50,820	595	50,225	28,225	22,000	0	0	0	0	22,000	5,500	0	0	0	0	5,500	16,500	32.5%
2003	76,514	626	75,889	40,056	35,832	0	3,318	0	10,514	22,000	11,000	0	2,750	0	2,750	5,500	24,832	32.5%
2004	226,201	3,699	222,501	169,215	53,286	0	4,406	27,185	10,695	11,000	19,250	0	2,750	11,000	2,750	2,750	34,036	15.0%
2005	1,033,975	19,288	1,014,688	650,202	364,486	5,111	13,110	33,411	92,854	220,000	106,861	5,111	8,250	13,750	24,750	55,000	257,625	24.9%
2006	4,385,102	99,514	4,285,588	2,903,968	1,381,619	27,199	81,200	131,237	338,984	803,000	425,949	27,199	55,000	49,500	93,500	200,750	955,670	21.8%
2007	3,153,713	124,861	3,028,853	2,295,179	733,673	52,870	82,998	118,652	39,154	440,000	275,620	52,870	55,000	46,750	11,000	110,000	458,054	14.5%
Total	9,057,666	255,244	8,802,422	6,170,977	2,631,444	86,332	196,849	316,062	492,201	1,540,000	861,832	86,332	132,000	123,750	134,750	385,000	1,769,612	19.5%
2005-2007	8,572,790	243,662	8,329,128	5,849,350	2,479,778	85,180	177,308	283,299	470,992	1,463,000	808,430	85,180	118,250	110,000	129,250	365,750	1,671,349	19.5%

Columns

(2) Column (3) + Column (4)
(3) Insurance Research Council, trended to 2012 at 1.5% total frequency and 8.0% annual severity
(4) Column (5) + Column (6)
(5) Insurance Research Council Data for emergency room treatments and tort qualification, trended to 2012 at 1.5% total frequency and 8.0% annual severity
(6) - (11) Insurance Research Council, trended to 2012 at 10.0% total frequency and 8.0% annual severity
(12) - (17) Columns (6) - (11) capped at $2,500 per claim
(18) Column (6) - Column (12)
(19) Column (18) / Column (2)

Analysis of Florida HB119

Exclusion of Massage Therapy & Acupuncture (lines 755-76)

	All Claims		Massage Claims			Acupuncture Claims						Massage + Acupuncture Claims	
Accident Year	Number of Claims	Total Allowed Payments	Allowed Payments 97124	Massage as a % of Total	Other MT as a % of Total	Allowed Payments 97810	Allowed Payments 97811	Allowed Payments 97813	Allowed Payments 97814	Allowed Payments Total	Acupuncture as a % of Total	Allowed Payments Total	as a % of Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
2005	204,053	619,320,895	52,553,952	8.5%	0.4%	1,186,528	188,037	901,176	155,705	2,431,445	0.4%	54,985,397	9.3%
2006	202,320	630,426,837	50,513,915	8.0%	0.4%	1,289,751	360,624	1,584,086	227,835	3,462,296	0.5%	53,976,211	9.0%
2007	195,362	661,505,773	56,585,298	8.6%	0.4%	1,739,480	463,264	1,146,895	251,423	3,601,063	0.5%	60,186,360	9.5%
2008	199,949	684,580,461	67,024,782	9.8%	0.4%	1,122,761	346,093	729,153	325,852	2,523,860	0.4%	69,548,641	10.6%
2009	163,530	897,618,496	111,452,654	12.4%	0.4%	1,098,619	375,200	578,908	303,985	2,356,712	0.3%	113,809,365	13.1%
2010	239,375	1,092,721,385	147,950,936	13.5%	0.4%	1,256,765	476,575	423,670	216,940	2,373,951	0.2%	150,324,887	14.2%
2011	206,389	855,644,075	109,393,999	12.8%	0.4%	1,080,203	465,487	334,688	182,305	2,062,684	0.2%	111,456,683	13.4%
2010-2011	445,764	1,948,365,460	257,344,935	13.2%	0.4%	2,336,968	942,062	758,359	399,245	4,436,635	0.2%	261,781,570	13.9%

Columns

(2) - (4) PIP Claim Data provided by Mitchell, International

(5) Column (4) / Column (3)

(6) Based on 2010 year of PIP Claim Data provided by Mitchell, International

(7) - (10) PIP Claim Data provided by Mitchell, International

(11) Column (7) + Column (8) + Column (9) + Column (10)

(12) Column (11) / Column (3)

(13) Column (4) + Column (11)

(14) Column 5 + Column 6 + Column (12)

Florida Office of Insurance Regulation Exhibit 8

Analysis of Florida HB119

Fix Medicare Fee Schedule (lines 1049-1057)

Accident Year	Total Charged	Fee Schedule Adjustments	Fee Schedule Percentage Removed	Estimated Fee Schedule Impact From Fast Track	Selected Fee Schedule Impact	Fee Schedule Use	Potential Savings
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2004	1,208,478,678	66,482,343	5.5%	0.0%			
2005	2,140,799,758	100,700,150	4.7%	0.0%			
2006	2,250,799,160	122,328,850	5.4%	0.0%			
2007	2,103,381,663	151,921,064	7.2%	0.0%			
2008	2,298,247,463	637,964,617	27.8%	0.0%			
2009	2,484,572,612	785,051,202	31.6%	0.0%			
2010	3,182,488,432	1,484,102,401	46.6%	0.0%			
2011	3,028,984,240	872,512,452	28.8%	0.0%	15.0%	90%	1.5%

Columns

(2) - (3)	PIP Claim Data provided by Mitchell, International
(4)	Column (3) / Column (2)
(5)	Estimated based on change in paid severity
(6)	Based on Column (4) and Column (5)
(7)	PIP Claim Data provided by Mitchell, International
(8)	Column (6) x [1 - Column (7)]

Analysis of Florida HB119

Insureds Refusal to Submit/Failure to Appear at 2 Medical Exams (lines 1522-1525)

Accident Year (1)	Total Claims (2)	Total Paid (3)	Refused IME Claims (4)	Refused IME Paid (5)	Refused IME Claims as a % of Total (6)	Refused IME Paid as a % of Total (7)
N/A	13	54,076	0	10,000	0.0%	18.5%
1997	1	13,719	0	13,719	0.0%	100.0%
1998	1	12,950	0	12,950	0.0%	100.0%
1999	1	11,505	0	0	0.0%	0.0%
2000	3	29,280	0	14,080	0.0%	48.1%
2001	4	24,020	0	11,845	0.0%	49.3%
2002	5	37,556	0	7,038	0.0%	18.7%
2003	8	55,270	0	14,892	0.0%	26.9%
2004	30	168,508	0	15,893	0.0%	9.4%
2005	128	970,269	3	244,296	2.3%	25.2%
2006	595	3,973,149	6	506,975	1.0%	12.8%
2007	570	3,179,355	3	244,473	0.5%	7.7%
2005-2007	1,293	8,122,773	12	995,744	0.9%	12.3%

Columns

(2) - (5)	Insurance Research Council
(6)	Column (4) / Column (2)
(7)	Column (5) / Column (3)

Attorney Fees Calculated w/o Contingency Fee Multiplier (lines 1543-1545)

Accident Year (1)	Total Claims (2)	Total Paid (3)	Attorney Claims (4)	Attorney Paid (5)	Attorney Claims as a % of Total (6)	Attorney Paid as a % of Total (7)
N/A	13	54,076	4	20,606	30.8%	38.1%
1997	1	13,719	1	13,719	100.0%	100.0%
1998	1	12,950	1	12,950	100.0%	100.0%
1999	1	11,505	0	0	0.0%	0.0%
2000	3	29,280	3	29,280	100.0%	100.0%
2001	4	24,020	4	24,020	100.0%	100.0%
2002	5	37,556	4	30,518	80.0%	81.3%
2003	8	55,270	5	39,835	62.5%	72.1%
2004	30	168,508	12	87,255	40.0%	51.8%
2005	128	970,269	75	631,525	58.6%	65.1%
2006	595	3,973,149	278	2,305,352	46.7%	58.0%
2007	570	3,179,355	138	1,180,583	24.2%	37.1%
2005-2007	1,293	8,122,773	491	4,117,460	38.0%	50.7%

Columns

(2) - (5)	Insurance Research Council
(6)	Column (4) / Column (2)
(7)	Column (5) / Column (3)

Attorney Fees Calculated w/o Contingency Fee Multiplier (lines 1543-1545)

		2008	2009	2010	1Q-3Q 2011
(1)	Loss & LAE Paid on Closed No-Fault Claims	$1,135,316,761	$1,232,926,735	$1,207,329,343	$1,243,016,500
(2)	Amount Paid to Defense Attorneys	33,413,744	22,352,901	25,284,727	26,618,543
(3)	Amount Paid to Plaintiff Attorneys	41,546,650	33,241,540	33,599,493	29,908,629
(4)	Total Attorney Fees	74,960,394	55,594,441	58,884,220	56,527,172
(5)	Defense Attorney Fees as a % Loss & LAE	2.9%	1.8%	2.1%	2.1%
(6)	Plaintiff Attorney Fees as a % Loss & LAE	3.7%	2.7%	2.8%	2.4%

Source: "Results from Recent Industry Survey on Florida Attorney Fees", PCI & PIF

	1st District Court of Appeals Counties	2011 Total Allowed
(1)	Escambia	6,609,423
(2)	1st District Counties Excluding Escambia	46,751,220
(3)	State Total Allowed	856,222,158
(4)	% of 1st District Excl. Escambia Claims Subject to Multiplier	10.0%
(5)	Escambia % of Statewide Claims Subject to Multiplier	0.772%
(6)	1st District Excl. Escambia % of Statewide Claims Subject to Multiplier	0.546%
(7)	1st District % of Statewide Claims Subject to Multiplier	1.318%
(8)	Attorney Fees as % of Total Allowed	5.0%
(9)	Contingency Fee Multiplier	2.5
(10)	Savings	0.2%

Rows	
(1) - (3)	PIP Claim Data provided by Mitchell, International
(4)	From claim representitive interviews
(5)	Row (1) / Row (3)
(6)	Row (2) x Row (4) / Row (3)
(7)	Row (5) / Row (6)
(8) - (9)	2011 PIP Working Group Report
(10)	Row (7) x Row (8) x Row (9)

Note: 1st District Court of Appeals includes counties Alachua, Baker, Bay, Bradford, Calhoun, Clay, Columbia, Dixie, Duval, Escambia, Franklin, Gadsden, Gilchrist, Gulf, Hamilton, Holmes, Jackson, Jefferson, Lafayette, Leon, Levy, Liberty, Madison, Nassau, Okaloosa, Santa Rosa, Suwannee, Taylor, Union, Wakulla, Walton, and Washington

Analysis of Florida HB119

Average Premium

Accident Year	BI Earned Premium	PD Earned Premium	PIP Earned Premium	Med Pay Earned Premium	UM/UIM Earned Premium	Comprehensive Earned Premium	Collision Earned Premium	Total Earned Premium
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2008	1,475,719,173	1,086,065,828	1,312,671,126	112,014,096	554,298,156	218,261,132	1,402,271,358	6,161,300,870
2009	1,457,782,926	1,063,135,654	1,269,837,116	96,218,799	544,242,062	213,637,680	1,282,332,419	5,927,186,657
2010	1,606,825,961	982,588,927	1,291,887,682	85,504,021	601,448,969	204,878,428	1,163,725,178	5,936,859,166
Total	4,540,328,060	3,131,790,410	3,874,395,924	293,736,917	1,699,989,187	636,777,240	3,848,328,955	18,025,346,693

Accident Year	BI Earned Exposure	PD Earned Exposure	PIP Earned Exposure	Med Pay Earned Exposure	UM/UIM Earned Exposure	Comprehensive Earned Exposure	Collision Earned Exposure	Total Earned Exposure
(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
2008	6,076,098	6,406,555	6,310,882	2,285,298	4,100,117	2,612,415	4,944,661	6,406,555
2009	5,957,520	6,271,594	6,319,700	2,144,723	4,011,687	2,520,396	4,801,306	6,319,700
2010	5,803,737	6,125,345	6,170,440	1,980,770	3,852,242	2,410,088	4,635,018	6,170,440
Total	17,837,355	18,803,494	18,801,021	6,410,791	11,964,046	7,542,899	14,380,985	18,896,694

Accident Year	BI Average Earned Premium	PD Average Earned Premium	PIP Average Earned Premium	Med Pay Average Earned Premium	UM/UIM Average Earned Premium	Comprehensive Average Earned Premium	Collision Average Earned Premium	Total Average Earned Premium
(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)
2008	242.87	169.52	208.00	49.02	135.19	83.55	283.59	961.72
2009	244.70	169.52	200.93	44.86	135.66	84.76	267.08	937.89
2010	276.86	160.41	209.37	43.17	156.13	85.01	251.07	962.15
Total	254.54	166.55	206.07	45.82	142.09	84.42	267.60	953.89

Data provided by Independent Statistical Services, Inc.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(1)	Have you used a % of Medicare schedule for claims payments?
(2)	If so, what %?
(3)	Did you attempt to use this but then change procedures due to court challenges?
(4)	Are you planning to use 80% of 200% of the Medicare fee schedule prospectively?
(5)	If not, what % do you plan to use?
(6)	Can you estimate what savings this would represent relative to what you are currently paying for PIP medical?
(7)	What fraud detection efforts are being used today by your companies? Are you aware of any fraud prevention activities that were in place on an industry level prior to the PIP reform?
(8)	Do you think the changes in the requirements as to the use of the long form Traffic Crash Report will have an impact on controlling fraud? If so, any estimate on how much?
(9)	Same question for the tightening of clinic licensing requirements (lines 331-334 of 3rd engrossed version of HB 119)?
(10)	Please give us your thoughts on the potential impacts of the Automobile Insurance Fraud Strike Force (478-613); also
(10a)	Effect of additional 60 days for fraud investigation (964-975)?
(10b)	Required reporting of claims denied for fraud to Div. of Ins. Fraud (975-977)? How do you report these today?
(10c)	Effect of penalties in the law for medical providers who engage in fraud (1746-1751)?
(11)	With respect to the elimination of massage therapy and acupuncture, please provide any estimated cost savings impacts your company may have?
(12)	What percentage of your total PIP claims losses are death benefits? (Dollars relative to total PIP losses and number of deaths for any claims with death benefits paid). Pinnacle will not publish any individual company statistics without prior approval of the company, we would only publish combined results for all companies who provide data).
(13)	Is your company paying attorney fee multipliers to PIP claimant attorneys in any Florida counties today?
(14)	If so in which counties or court jurisdictions and any estimates you can provide of dollars of attorney fees subject to multipliers?

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(15)	Estimated impact of new statutory language requiring insured to comply with policy provisions including Examination Under Oath (1428-1439)?
(16)	Estimate of impact of additional language requiring insureds to appear at IME's and rebuttable presumption after two failures to appear?
(17)	With respect to the requirement for initial services within 14 days (677-679), has your company observed any change in the length of time it takes claimants to receive initial services since 2007 and if so, what change?
(18)	What percentage of your PIP losses would you classify as "non-emergency" under the new law definition (632-653)? (% of claims and dollar amounts if possible)
(19)	Do you think the change in the limit for non-emergency treatment limit to $2500 will be effective? If not, why not?
(20)	What impact do you think the repayment of Medicaid within 30 days will have (821-823)?
(21)	What were the major drivers in PIP claim costs prior to the PIP reform?
(22)	Do you foresee the PIP reforms having a major impact on the PIP cost increase drivers?
(23)	What unexpected consequences do you foresee of the PIP legislation reform?
(24)	Have you noticed a slowing or speeding up of claims reporting? If so, to what extent? Do you attribute this to anything in particular? What changes, if any, has this caused in your claims handling practices?
(25)	For commercial auto writers, what unique problems or impacts do you foresee?
(26)	Can we cite your comments in our report?
(27)	Any additional comments or concerns you would like to bring to our attention?

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(1) Have you used a % of Medicare schedule for claims payments?
(2) If so, what %?

Insurer #	(1)	(2)	Comment
1	Yes		Protocols and Medical Fee Schedule is in place and used to determine what is reasonable.
2	Yes	200%	
3	Yes	80%/200%	
4	Yes	80%/200%	
5	Yes	80%/200%	Began using in 2007
6	No		
PIFF	Yes	80%/200%	Generally, as authorized under Florida law, carriers look to the Medicare fee schedule to help them determine what the reasonable amount of payment should be. Generally, carriers pay an amount equal to 80 percent of 200 percent of the Medicare Part B Participating Physicians fee schedule as a reasonable amount.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(3) Did you attempt to use this but then change procedures due to court challenges?
(4) Are you planning to use 80% of 200% of the Medicare fee schedule prospectively?
(5) If not, what % do you plan to use?

Insurer #	(3)	(4)	(5)	Comment
1	No change			Still Using. Sometimes it is less, sometimes more. Did originally apply Outpatient Pay System (OPPS) (Medicare Protocol for MRIs but had to eliminate due to litigation. Also used the following protocols: MPPR = Physical Therapy MDIR = Multiple Diagnostic Imaging Rations where more than 1 imaging on same day pays 100% for 1st, 75% for 2nd, 50% for others. NCCI = National Correct Coding Initiative
2	No change	80%/100%		No change from current practice -Statute & policy states that they will pay reasonable amount. Offers 80% and 100% depending on endorsement.
3				At the end of 2007 No-Fault was to disappear, unsustainable. Providers and Lawyers got it reinstated, but with fee schedule. But subsequent decisions have weakened this requirement. Waiting for FL Supreme Court to overrule. October 2011 changed policy language to explicitly use the fee schedule.
4	No change	Yes		Fortunate to change policy language in 2009/2010 and solidified stance in using it. Will continue to use 80% of 200%. There will be an impact for companies that did not change language and are now catching up.
5	Yes	Yes		Over 10,000 lawsuits.
6	No	No	N/A	Insurer's PIP is commercial and rental cars and most PIP claims will shift to the claimant's personal auto policy. They generally pay 80% of the bill up to $10,000.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(3) Did you attempt to use this but then change procedures due to court challenges?
(4) Are you planning to use 80% of 200% of the Medicare fee schedule prospectively?
(5) If not, what % do you plan to use?

PIFF	Yes	Yes	N/A	The fee schedule changes that went into effect in 2008 led to an unexpected deluge of lawsuits related to their application and to the "reasonableness" of the amount paid by the carriers under the applicable fee schedule. Generally speaking, this is in industry-wide phenomenon. Generally, carriers intend to look to the Medicare fee schedule as authorized by statute to determine proper billing amounts. New changes to the schedule will apply to hospitals, ambulatory surgical centers, and durable medical equipment providers, and carriers anticipate applying the schedule for payments to these providers.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(6) Can you estimate what savings this would represent relative to what you are currently paying for PIP medical?

Insurer #	(6)	Comment
1	10%	Estimate 10% annually in savings if could apply all the protocols. Fee schedule without treatment protocols could result in higher costs. NCCI: $1.4-$1.8 million in savings. Comprehensive Code and Component Code. Comprehensive Code for appendectomy and separate code for incision. In PIP there is a manipulative therapy codes, which is a comprehensive code and a separate code for massage. NCCI is a tool to prevent double coding. Adverse decision from 5th District Court last week. HB119, Line 1071, Insurers will likely argue that MPPR, OPPS and NCCI allowed but plaintiffs may litigate.
2		No savings because current practice is not changing. Bill codifies that you must have it in your contract and provide policyholder notice.
3	Large	No specific numbers. Two numbers. Indemnity and Expense. Think enormous savings on Indemnity side (versus not using it). Changed policy last Fall. But some erosion by excessive treatment. Expenses should be large savings as well. Attorney fees FL courts award $350-$500/hour.
4	0%	No change.
5	Significant	No estimate but is “significant”. Without the fee schedule have no objective standard
6	0%	No change.
PIFF		This savings is difficult to quantify across the carriers. Short-term savings by application of the fee schedules may be offset by attorneys fee payments incurred to defend lawsuits challenging these provisions. If Florida courts ultimately uphold the applicability of these fee schedule changes, there may be some potential savings, but industry experience in the wake of the 2007 changes indicates that the savings can be offset by increased frequency of treatment and increased use of other modalities of therapy.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(7) What fraud detection efforts are being used today by your companies? Are you aware of any fraud prevention activities that were in place on an industry level prior to the PIP reform?

Insurer #	(7)	Comment
1	SIU	Routinely looking at fraud today through SIU. MCIU (Multiple Claim Investigative Unit) fraud across multiple claims. Immunity statute allows companies to share fraud information with others. NATB is active in FL and works with local fraud. Required under statute to report potential fraud. Arrest data is kept on PIP arrests.
2		Vast investigative efforts. Investigate claim and policy details. Speak with policyholders, claimants, police, witnesses. Review medical reviews, reports, request medical examinations. Compares statistics. Very active in industry efforts. Attends meetings to stay up to date on any changes in regulations/statutes.
3		Pursuing efforts in line with Industry. Identifying staged losses, misrepresented clinic ownership, etc. True Fraud abuse is only a small portion. Non-classic is really abuse, interpretation by courts, excessive fees.
4		No comment
5	SIU	Have a number of efforts: SIU; training of claims adjustors to look for fraud. Industry efforts: there are trade groups. NATB. Believes the current anti-fraud efforts by DFS have not been that effective.
6	SIU	Internal SIU conducts field investigations and makes recommendations to NICB, law enforcement or no conclusion. SIU tracks providers and attorneys through NICB and looks for patterns.
PIFF	SIU	Generally speaking, carriers are actively involved in the identification, investigation, and prosecution of PIP fraud, through internal SIU operations and in coordination with state and local law enforcement and the state Division of Insurance Fraud. The National Insurance Crime Bureau, the Department of Financial Services, Office of the Insurance Consumer Advocate, and the Division of Insurance Fraud actively track fraud referrals, investigations, and prosecutions in Florida.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(8) Do you think the changes in the requirements as to the use of the long form Traffic Crash Report will have an impact on controlling fraud? If so, any estimate on how much?

Insurer #	(8)	Comment
1	Marginal	Marginal Impact. These forms are often done today.
2	Marginal	Marginal impact at best. Currently many of the clinics require that patients provide police log before treating. Concerned that police cannot testify or provide affidavit. Fraudsters may teach injured parties what to say/not to say to police officers.
3	Small	Expect small impact. Difficult to speculate. Should be helpful in reducing phantom passengers.
4		No comment
5		Yes, should have an impact. Difficult to estimate the savings.
6	Very Little	Probably not, similar changes were made in NY and fraud perpetrators learned ways around, very little impact
PIFF		We do not know what the effect of this change will be.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(9) Same question for the tightening of clinic licensing requirements (lines 331-334 of 3rd engrossed version of HB 119)?

Insurer #	(9)	Comment
1	Some	Have several "de facto ownerships" cases. So some effect on eliminating exceptions to licensing requirements.
2	Marginal	Marginal. Impact will come from complex, organized fraud nature. May force consolidation of clinics and small mom/pop clinics will need to shut down. Will allow it to be easier to track the larger clinics. Enforcement of these requirements will be difficult.
3		Should be helpful, but not much cost savings. Difficult to enforce. EUO's of providers not required.
4		No comment
5	Big	Yes is a big benefit. Also making lying as to clinic ownership a criminal offense
6		Probably not, should have abolished PIP to get rid of the problems. In CO, 96% of the accidents over $50,000 had on property damage. CO got rid of PIP and rates came down.
PIFF		We do not know what the effect of this change will be. Historically, the clinic regulatory regime in Florida is problematic, with large numbers of self-exempt clinics billing PIP services. Appropriate regulatory agencies, such as the Department of Health and the Agency for Health Care Administration, have expressed concern about their ability to adequately police these clinics. The definition of a "wholly owned" clinic, which applies under the new law, may add a level of transparency and improved regulatory oversight over these clinics, assuming that state regulatory agencies are vigilant in prosecuting wrongdoers under the law.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(10) Please give us your thoughts on the potential impacts of the Automobile Insurance Fraud Strike Force (478-613); also

(10a) Effect of additional 60 days for fraud investigation (964-975)?
(10b) Required reporting of claims denied for fraud to Div. of Ins. Fraud (975-977)? How do you report these today?
(10c) Effect of penalties in the law for medical providers who engage in fraud (1746-1751)?

Insurer #	(10a)	(10b)	(10c)	Comment
1	None	None	Marginal	a) No impact, because able to investigate in 30 days. Concerned that new law requires notification of claimant within 30 days if investigating fraud which could hurt efforts. b) No impact, required under 626.989(6); they report suspected fraud do DFS today c) marginal impact as very few prosecutions Fraud Strike Force - cautiously optimistic 1) Increase identification 2) Increase public awareness 3) Unbiased voice for future needed law changes
2	Marginal		Very Limited	Wait and see approach. Anticipate more significant benefits longer term as infrastructure takes place. Statute talks about establishment of strike force but not enough clarity about how quick for strike force to be up and running. Not clear on how it will operate, and funding. How much money they have will determine how much they can do. There is an anti-fraud effort underway by CFO but it is not dedicated to auto alone. Currently no dedicated resources for auto. a) Time frames in the past so SIU already meets the 30 day time frame. Concerned that penalty payments might offset any money they could save. Now - During investigation no penalty and if pay claim, penalty from day 31. New rule starts penalty at day 1. b) Report to NICB and NICB sends to Division of Insurance Fraud c) Very limited impact. Very few cases in FL go to trial and result in convictions. Stronger penalties may be discouraged. For every clinic shut down, 2 more will pop up. It is easy for someone to set up a clinic - $20,000 & post office box.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(10) Please give us your thoughts on the potential impacts of the Automobile Insurance Fraud Strike Force (478-613); also

(10a) Effect of additional 60 days for fraud investigation (964-975)?
(10b) Required reporting of claims denied for fraud to Div. of Ins. Fraud (975-977)? How do you report these today?
(10c) Effect of penalties in the law for medical providers who engage in fraud (1746-1751)?

3	Minimal			a) Minimal Savings b) Pick and choose battles. New law won't change insurer's practice. c) Too speculative. Incentive in penalties does not outweigh the financial gain of Fraud.
4				No comment
5	None		Positive	yes believes it can help a) No effect b) Yes, report suspected fraud today, but very difficult to prove. c) Positive, but must go after the providers as well as the lower level folks
6	None			a) Investigations take longer and people disappear and do not cooperate. b) Normally report to the appropriate party so it will not be much different. c) Do not know if it will make much difference. In NY after pleading guilty they are right back in business. The penalties are not large enough.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(10) Please give us your thoughts on the potential impacts of the Automobile Insurance Fraud Strike Force (478-613); also

(10a) Effect of additional 60 days for fraud investigation (964-975)?
(10b) Required reporting of claims denied for fraud to Div. of Ins. Fraud (975-977)? How do you report these today?
(10c) Effect of penalties in the law for medical providers who engage in fraud (1746-1751)?

PIFF		None	Marginal	Generally speaking, the carriers are hopeful that the Strike Force will increase public awareness of the problem of automobile insurance fraud; increase the identification and prosecution of those involved in automobile insurance fraud; and serve as an objective voice for needed additional PIP reform, to include the possibility of repeal if appropriate, in future legislative sessions. (a) We do not know what the effect of this change will be. The 60 day fraud language contains vague terms that may drive litigation over this provision, making it unusable. (b) No impact, as carriers are required by law to make these reports. (c) There may be some marginal benefit, likely through the slightly increased deterrent effect of these provisions. The barriers to entry into the PIP fraud world are so slight, and the number of criminal enterprises that are involved in PIP fraud is so great, that this heightened penalty may not be of great significance, particularly when compared to the possible immediate cash returns from committing fraud.

HB 119 Claims Interview/Survey

(11) With respect to the elimination of massage therapy and acupuncture, please provide any estimated cost savings impacts your company may have?

Insurer #	(11)	Comment
1	13%	Believe that these costs will be shifted to other procedures or shift to physical therapy. 2011 had 12.4% of PIP losses went to massage therapy (CPT code 97124) and 0.3% paid due to acupuncture
2		We learned lesson from 2008 statute change. Medical providers change to other modalities of treatments. After 2008 therapy modalities and time increased to make up lost revenue from fee schedule. Expect providers to shift/change treatment patterns to reimbursable modalities.
3	Minimal	No statistics. Think this will play out that whatever savings potential will be eliminated by code shifting. Minimal savings expected. CPT codes on massage to be excluded. No answer. Any dollars identified would be appreciated. Insurer not providing data. May get a percentage.
4	Minimal	No specifics, expect minimal impact.
5		Submitting thru PIF, but likely to move the treatment to other codes
6		No will just go get some other treatment. Will find a way to charge insurer. Doubt it will save money.
PIFF	10.0%	Important note: While these costs will be avoided beginning January 1, 2013, medical providers may shift to other covered modalities (physical therapy, etc.). Insurer data should indicate whether this cost-shifting is occurring by Q3 2013.

HB 119 Claims Interview/Survey

(12) What percentage of your total PIP claims losses are death benefits? (Dollars relative to total PIP losses and number of deaths for any claims with death benefits paid). Pinnacle will not publish any individual company statistics without prior approval of the company, we would only publish combined results for all companies who provide data).

Insurer #	(12)	Comment
1	0.20%	1st 6 months of 2012 death benefits as a % of total PIP payments=0.2%
2	0.18%	Very, very small percentage. The new statute will increase less than 0.2% as a result that the death benefit is an additional payment. % of death benefit claims are higher.
3	Minimal	Minimal increase expected. Between 2009-2011 (3 years) only 59 PIP death claims.
4		No comment
5		Submitting thru PIF.
6	< 1%	Very rare, not many in FL. 1% or less.
PIFF	0.2%	

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(13) Is your company paying attorney fee multipliers to PIP claimant attorneys in any Florida counties today?

(14) If so in which counties or court jurisdictions and any estimates you can provide of dollars of attorney fees subject to multipliers?

Insurer #	(13)	(14)	Comment
1	Yes	Escambia	Escambia County is the primary county where they see multipliers today. Can get $300-$400 per hour in many counties which is a defacto multiplier
2	No	N/A	Were being awarded several years ago but nothing in the last few years.
3	No	N/A	No. Settling in advance of Trial. Uncapped and excessive attorney awards far outweigh PIP litigation. Other carriers thought multiplier was a big deal, but Insurer 3 does not see it that way. No multiplier experience so no jurisdictions to report.
4			No comment
5	Yes	Escambia	Escambia County; selective in other
6	No	N/A	Does not believe so.
PIFF			Generally speaking, PIP plaintiffs' attorneys often request contingency fee multipliers in an attempt to increase their leverage in PIP lawsuits. Multipliers are awarded by county court judges, but trending these awards is difficult. The award of multipliers appears to be relatively uncommon; however trial lawyers have been able to obtain fee awards in the $300-$400 hourly range even without the multiplier, in effect receiving a de facto multiplier for cases that do not require great effort or time to prosecute. Carriers do not track this information.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(15) Estimated impact of new statutory language requiring insured to comply with policy provisions including Examination Under Oath (1428-1439)?

(16) Estimate of impact of additional language requiring insureds to appear at IME's and rebuttable presumption after two failures to appear?

Insurer #	(15)	(16)	Comment
1	Marginal	Marginal	(15) May be some marginal benefit, but new language may be ambiguous (16) Marginal benefit
2		Minimal	(15) We feel that our policy was sound before new reform bill and would force EUO when necessary. Only downside they see is that will fight more lawsuits about being required to submit to EUO. No real impact. (16) Would be beneficial to requiring the physician to sit in on examination but that did not make it into bill. There was case law for this before but now in statute. Only impact is that occasionally would get lawsuit so there may be some ALAE savings. Extremely minimal impact.
3			(15) Stronger if allowed to take provider EUOs. (16) Policy already required. Not sure that the rebuttable presumption after 2 failures will hold.
4			No comment
5			(15) Already had the policy provision but this clarifies (16) Helpful
6			(15) Used to do this anyway and might have a little impact if more teeth, such as denying coverage for those that do not provide examination under oath. Have used this successfully in NY. (16) Not make much difference. Before you can schedule the IME, they claimant will be through the $10,000. Expect court to nullify if use IME without reason. Treatment isn't stayed until the claimant shows up for the IME.
PIFF			We do not know what the effects of these changes will be.

HB 119 Claims Interview/Survey

(17) With respect to the requirement for initial services within 14 days (677-679), has your company observed any change in the length of time it takes claimants to receive initial services since 2007 and if so, what change?

Insurer #	(17)	Comment
1		No analysis, 91% sought treatment within 14 days.
2	No	Have not noticed any change in reporting patterns
3		Nearly all PIP claimants present within 14 days. Lawyers and providers getting message out now. Expecting more treatments, and earlier, implying emergency room costs (higher rates). No real savings here.
4		No comment
5		Submitting through PIF
6	No	Not really
PIFF	5.4%	

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(18) What percentage of your PIP losses would you classify as "non-emergency" under the new law definition (632-653)? (% of claims and dollar amounts if possible)

(19) Do you think the change in the limit for non-emergency treatment limit to $2500 will be effective? If not, why not?

Insurer #	(18)	(19)	Comment
1	15-20%	No	(18) Physician determination so don't have. 24% of claims and 3.8% of claim dollars had medicals of $2500 or less today. (19) No. Clinics will likely routinely certify as emergency. Also any savings likely to be shifted to BI
2		None	On the surface, it sounds like a good thing but don't expect to get any benefit. Provision has biggest opportunity for loopholes and work arounds. Definition of non-emergency will be challenged in courts. Advertising already for staffing companies to help clinics determine emergency/non-emergency so that clinic does not leave $7,500 on table. Attorneys are soliciting if your insurance company declares your condition a non-emergency, contact us and we'll go to court. Expects very few claims to be classified as non-emergency, especially for chiropractors where most abuse takes place. Will drive up expenses. These ads are a little different than normally seen, reference changes in the statute -- months before provisions actually go into law - 1/1/2013. Already working on loopholes and still have time to come up with more schemes. Very easy for chiropractors to get someone authorized to make an emergency declaration. An authorized provider will determine emergency condition - will be difficult to win in court since provider is authorized (expert) versus company's expert. There is no appeal provision on whether or not company can appeal the decision that it is an emergency medical condition. Expect challenges in court. Will be arguing with clinic and claimant will not be available as witness
3			Tough to quantify. Think non-emergency claims will be reclassified as emergency. Statute has a pretty low standard. Just have to show severe pain. Pre-emptive ads marketing emergency classification. Skeptical this will have any impact.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(18) What percentage of your PIP losses would you classify as "non-emergency" under the new law definition (632-653)? (% of claims and dollar amounts if possible)

(19) Do you think the change in the limit for non-emergency treatment limit to $2500 will be effective? If not, why not?

4			Do not know what impact this will have. The new definition is confusing and difficult to understand.
5			(18) Lot of guesswork as to whether it is an emergency or not. Potential for significant savings if upheld by the courts and they (19) It depends on whether or not the courts uphold the law as written and how much abuse in coding the injury as emergency.
6	80%		80% are soft tissue and chiropractic claims. Possible impact if it does not get challenged and through out as expected.
PIFF			(18) This definition will apply to claims filed on or after January 1, 2013; therefore the carriers have no experience data on the application of the definition. We do not know whether the definition will be applied uniformly and correctly, and we do not know the degree to which providers will "game" the application of the law by determining most injuries to meet the EMC standard. (19) The impact of the EMC threshold is uncertain. Providers have already begun to solicit services from third parties who promise that their patients will be determined to have an EMC. Unscrupulous clinics, who have historically profited from the manipulation of the PIP system, are no less likely to do so under the new EMC provision. The EMC is very likely to be litigated, and court rulings may eviscerate the definition's practical meaning.

Florida Office of Insurance Regulation
Analysis of Florida HB119
HB 119 Claims Interview/Survey

(20) What impact do you think the repayment of Medicaid within 30 days will have (821-823)?

Insurer #	(20)	Comment
1	Small	Believes this is small. PIP claims generally want PIP, not Medicaid.
2	None	No impact, already being done. Any claim is adjusted and paid within 30 days.
3	None	No impact.
4		No comment
5	None	No, reimburse liens today.
6	None	Already adhere to standard.
PIFF		Generally speaking, carriers have limited experience with this requirement and do not foresee significant numbers of claims meeting the repayment requirement.

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(21) What were the major drivers in PIP claim costs prior to the PIP reform?

Insurer #	(21)	Comment
1		1) PIP Litigation - cottage industry of lawyers specializing in PIP claims. 2) PIP Clinics 3) Ownership of PIP clinics 4) Absence of protocols underlying # of treatments, massage therapy 5) Attorney fees for PIP/Litigation Costs 5) Attorney ads, billboards
2		Consumer Advocate did a nice job of analyzing FL No-Fault costs. 1) Fraud imbedded in market place. 2) Most staged accidents in the country. 3) Fraud rings know how to beat system. 4) FL leads list in fraud. 5) Fraud by insured, providers 6) Medical overutilization; fee schedule caps resulted in more services and/or higher priced services; was hoping for more complete fee schedule including utilization protocols. 14 days and non-emergency will not take the place of utilization protocols. Provisions have good intentions but don't expect benefits to materialize - work arounds, new fraud schemes After previous reform, loss costs spiraled up. Do not see much of that going away with new bill.
3		Same drivers before and after: Fee awards, Judiciary, Abuse of Billing Practices.
4		No comment
5		Main drivers were hard and soft fraud, systemic overcharging and over treating of PIP claimants and costs of excessive litigation/income to plaintiffs lawyers
6		Fraud, most is done by illegal immigrants.

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(21) What were the major drivers in PIP claim costs prior to the PIP reform?

PIFF		The Office of Insurance Regulation, the Insurance Consumer Advocate, the Insurance Research Council, the Insurance Information Institute, and other parties have identified three distinct cost drivers affecting PIP: Insurance Fraud, Medical Provider Overutilization and Medical Inflation, and Litigation Growth. These cost drivers are well documented in recent studies by these groups.

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(22) Do you foresee the PIP reforms having a major impact on the PIP cost increase drivers?

Insurer #	(22)	Comment
1	No	No, will add to uncertainty
2	No	Some people think this will drive up costs. May have marginal cost savings and don't expect anything significant. Expects revisitation for lack of effectiveness in a couple years.
3	No	
4		No comment
5		Initially will increase PIP costs through increased litigation. Savings may ultimately depend on whether the county court judges enforce the words of the new statute.
6	No	
PIFF		Generally speaking, carriers are unsure of whether and to what extent the changes to PIP will affect system costs. The wholesale corruption of the No-Fault system by the cottage industry of trial lawyers, unscrupulous PIP clinics, lawyer-medical referral services, and criminal gangs is very difficult to overcome through legislative changes. Even with comprehensive reform, carriers believe that the prevalence of fraud will remain high.

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(23) What unexpected consequences do you foresee of the PIP legislation reform?

Insurer #	(23)	Comment
1		1) Increase in Litigation 2) No requirement that physicians let them know which are emergency 3) Shifting of costs from PIP to BI 4) Fraud notice provision may cause insurers to not be able to deny due to lack of 31 day notice 5) Rise of massage & acupuncture lobby to contest HB119 and future litigation 6) Line 1084 leads to potential gap between 7/1/12 to 1st policy effective date after 1/1/13
2		A lot of abuse in today's system with chiropractors. There was one point in the legislature that chiropractors/acupuncture was excluded but they added back in. The non-emergency limit is the indirect way to get at chiropractors but expect they will work around. A chiropractor can use an advanced nurse practitioner in their office and the nurse can determine that it is a medical emergency and refer back to the chiropractor and get the full $10,000 coverage. Will continue have the same problems with chiropractor. $2500 limit will be litigated. Expect attorney fees to increase. Same medical costs as today + increase in attorney fees. Easy for someone to expect treatments paid to chiropractor/massage to go away but the costs will shift to others. Lots of money at stake and unethical people making money off the system will find another way to make money.
3		Unintended litigation. A few more ambiguities will lead to additional litigation.
4		No comment
5		Increased litigation; individual interpretations by judges and potential for retroactive effect of the rulings
6		Increase litigation costs. Lots of portions of law will be litigated, already see ads to encourage chiropractic care.

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(23) What unexpected consequences do you foresee of the PIP legislation reform?

PIFF		Carriers saw a major increase in claims activity in the wake of the 2007 PIP reform law, with related increases in litigation. We anticipate the same after the new law goes into effect in January. There is no requirement that providers inform carriers at the time of billing whether an EMC or a non-EMC condition exists, potentially creating confusion for insureds who will not know what benefits they may be entitled to, and preventing insurers from determining what benefits are owed in a timely manner. A shift of claims from PIP to BI or UM is possible, as these benefits do not have the same anti-fraud tools applicable to them. The fraud notice provision may create scenarios where denials based on fraud are challenged on the basis of the statutory language. Massage and acupuncture lobbies, and their strong allies in the chiropractic lobby, are marshaling themselves to restore these modalities to the PIP law. Litigation over clarifications and revisions to the fee schedule is likely.

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(24) Have you noticed a slowing or speeding up of claims reporting? If so, to what extent? Do you attribute this to anything in particular? What changes, if any, has this caused in your claims handling practices?

Insurer #	(24)	Comment
1	No	No
2	No	Noticed no changes in reporting patterns.
3	No	No notice of change in claim reporting. Status Quo.
4		No comment
5	No	No
6	No	Consistent. The only run into late reporting is the PIP collection firms that are trying to get ambulance and hospital bills that were not reported by our insured due to coverage not being primary. Insureds are efficient about reporting to meet the current requirements.
PIFF		

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(25) For commercial auto writers, what unique problems or impacts do you foresee?

Insurer #	(25)	Comment
1		Don't see anything unique.
2		Not as impacted as personal lines. Overall believe good intentions in bill - manage medical costs, deter fraud. Expect that work arounds and loopholes exist so savings will not materialize. Minor problem for taxicabs - could get reimbursement if passenger was injured but not allowed any more - minor impact. View does not differ much from the personal lines side.
3		Nothing unique to commercial over personal.
4		No comment
5		Same problems
6		Will not make much difference. Workers Compensation is often primary, some use PIP until Workers Compensation kicks in. It is usually not the primary coverage.
PIFF		Not applicable.

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(26) Can we cite your comments in our report?

Insurer #	(26)	Comment
1	Yes	OK, but do not attribute to company or person.
2		Will not mention company name.
3		
4		Will not mention company name.
5	Yes	Yes if identified as Insurer #x.
6	Yes	Will not mention company name.
PIFF	Yes	Yes, with appropriate reference to the trade association response.

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(27) Any additional comments or concerns you would like to bring to our attention?

Insurer #	(27)	Comment
1		None
2		Reform is a step in the right direction but did not go far enough in medical management. From past reform efforts, good intentions do not always generate expected results. 2008 reforms showed improvement in the 1st year but then fraudsters/providers figured out how to work around the reforms. 2008 was unique in that no-fault went away in 2007 and reform and no-fault came back. This bill was enacted in March but doesn't go into affect into 2013 giving everyone time to figure out how to work around it now so not much savings even initially.
3		General thoughts: The real drivers of the cost of PIP were not addressed as strongly as they could have been in the new law.
4		It is too early to tell since many components are not effective until the end of the year. It seems reasonable to expect that there would be some benefit but it is hard to say how much yet. It will depend on legal establishment reaction and reaction by fraudsters. Fraudsters will find ways to work around and not be put out of business.
5		The expectation that this legislation will reduce costs will not happen unless courts enforce it.
6		Abolish PIP to solve problems. It is a license to steal and should have gotten rid of it.
PIFF		Not applicable.