



# The Florida Senate

Issue Brief 2012-203

September 2011

---

Committee on Banking and Insurance

---

## PERSONAL INJURY PROTECTION (PIP)

### Statement of the Issue

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.

Recently, Florida has experienced an increase in motor vehicle related insurance fraud and the costs associated with PIP coverage. In the 2011 Legislative Session, a number of bills were offered that contained various proposals that sought to address the rising costs in the PIP system. This issue brief outlines the current PIP system, recent trends in PIP fraud, recent trends in PIP costs on a statewide and a regional basis, and relevant legislative proposals offered during the 2011 session.

### Discussion

#### *History of the No-fault Law in Florida*

In 1971, Florida became the second state in the country to adopt a no-fault automobile insurance plan which took effect January 1, 1972.<sup>1</sup> The no-fault plan was offered as a replacement for the tort reparations system, with the purpose of serving as a means to quickly and efficiently compensate injured parties in auto accidents regardless of fault. The proponents of no-fault insurance promoted it as a more efficient and fair means of providing redress to automobile accident victims. They believed that this system provides compensation in a swifter fashion than the tort system, and that no-fault would lower the cost of insurance, with both benefits being primarily produced by reducing litigation. The principle underlying no-fault automobile insurance laws is a trade-off of one benefit for another, by assuring payment of medical, disability (wage loss) and death benefits, regardless of fault, in return for a limitation on the right to sue for non-economic damages (pain and suffering).

The objectives of the no-fault law were enumerated by the Florida Supreme Court in 1974 in *Lasky v. State Farm Insurance Company*<sup>2</sup>. The Court opined 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.

In the ensuing 40 years, the Legislature has periodically revised the no-fault law, courts have interpreted its key provisions, and various constituent groups have analyzed its impact upon Florida motorists. More recently, 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 re-enacted the law prior to such date. While the sunset provision actually did take effect on October 1, 2007, the Legislature re-enacted the no-fault law, effective

---

<sup>1</sup> The Florida Automobile Reparations Reform Act, known generally as the "nofault law," was passed by the Florida Legislature on June 4, 1971, and became law effective January 1, 1972. Chapter 71-252, L.O.F. The legislature amended the name to "The Florida Motor Vehicle No-Fault Law" in 1982. Chapter 82-243. L.O.F.

<sup>2</sup> *Lasky v. State Farm Ins. Co.*, 296 So.2d 9, 14 (Fla. 1974).

January 1, 2008, with several changes (including use of fee schedules for some services) designed to help control medical costs.

### ***Current Provisions of Florida's No-fault Law***

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and noneconomic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of \$10,000 for bodily injury to any one person and \$20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income and 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a \$10,000 minimum benefit. A \$5,000 death benefit is also provided.

When the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law in 2007,<sup>3</sup> the re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to \$10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals; or
- Licensed health care clinics that are accredited by a specified accrediting organization.

### ***Medical Fee Limits for PIP Reimbursement***

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B; and,
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer

---

<sup>3</sup> Sections 627.730-627.7405, F.S., effective January 1, 2008.

limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP co-insurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

### ***Motor Vehicle Insurance Fraud***

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled *Florida's Motor Vehicle No-Fault Law*, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud (Division)<sup>4</sup> during the three fiscal years beginning in 2002 and ending in 2005.

More recently, the Division has reported even greater increases in the number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. As a significant subset of the overall fraud referrals, the number of staged motor vehicle accidents received by the Division nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). Florida led the nation in staged motor vehicle accident "questionable claims"<sup>5</sup> from 2007-2009, according to the National Insurance Crime Bureau (NICB).<sup>6</sup>

Representatives from the Division have identified the following factors as contributing to the magnitude of Florida's motor vehicle insurance fraud problem:

- Ease of health care clinic ownership.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services. Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

### ***OIR Personal Injury Protection Data Call***

On April 11, 2011, the Office of Insurance Regulation (OIR) issued its *Report on Review of the 2011 Personal Injury Protection Data Call*.<sup>7</sup> In describing the scope of its Data Call, OIR stated:

Thirty-one companies participated in the Data Call, which covered a scope period from 2006-2010. Twenty-five of those companies represent 80.1% of the market place based on 2009 Total Private Passenger Auto No-Fault Premiums reported to the NAIC. The claim data is based on the date the claim was opened or recorded on the company's system. Closed Claim data is based on the date the claim was closed regardless of when it was opened or recorded.

The data submitted was checked for data integrity, however, the information in this report is based upon the information as received and no audit of the data has been performed.

OIR collected and compiled the data on both a statewide and a regional level basis. Additionally, OIR obtained data from Mitchell International, Inc. ("Mitchell"), which it described as follows:

As a provider of Property & Casualty claims technology solutions, Mitchell International, Inc. ("Mitchell") processes over 50 million transactions annually for over 300 insurance companies. Mitchell has at least 62 customers in the auto insurance market that utilize their medical claims software, DecisionPoint. Mitchell supplied data to the Office which provided a high level review of national trends and the experience here in Florida. The results show that Florida is above the national average in many instances, including provider charges per claim and the average number of procedures per claim.

<sup>4</sup> The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.

<sup>5</sup> The NICB defines a "questionable claim" as one in which indications of behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.

<sup>6</sup> The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies.

<sup>7</sup> A full copy of the report can be obtained from [http://www.floir.com/siteDocuments/PIP\\_04-08-2011.pdf](http://www.floir.com/siteDocuments/PIP_04-08-2011.pdf), last visited on August 11, 2011.

Accordingly, the OIR report contains compilations of data on a national basis, a Florida statewide basis, and on a regional basis. Some of the significant trend comparisons revealed by the report are as follows:

#### **Statewide Data**

- The number of licensed drivers in Florida has remained relatively constant between 2004 and 2011, and actually decreased by 0.5% from January 1, 2008 and January 1, 2011.
- The number of crashes in Florida decreased by 8% between 2007 and 2009, and the number of crashes with injuries decreased by 7.3% between 2007 and 2009.
- Notwithstanding the decreasing trend in the number of drivers, the number of crashes, and the number of injuries, the number of PIP claims that were opened in Florida increased by 35.7% from 2008 to 2010.
- Total PIP payments made by insurers increased by 70% between calendar years 2008 and 2010.
- The number of PIP claims that were closed with payment increased by 59.4% between calendar years 2008 and 2010.
- The number of PIP-related lawsuits that were settled increased by 153.3% between calendar years 2008 and 2010.

#### **Regional Data**

- In 2010, twenty-seven percent of the state's licensed drivers were in South Florida, while 55% of the state's PIP benefits were paid in South Florida.
- While the percentage of total claims opened in a particular region remained relatively constant for all regions for the period 2006 to 2008, the percentage increase in the number of claims opened by region for the period 2008 to 2010 was: South Florida 55%; Tampa, St. Pete 33%; Southwest Florida 31%; Central Florida 23%; Northeast Florida 15%.
- The number of total PIP payments also remained relatively constant for all regions for the period 2006 to 2008, but the percentage increase in total PIP payments by region for the period 2008 to 2010 was: South Florida 88%; Tampa, St. Pete 55%; Southwest Florida 41%; Central Florida 28%; Northeast Florida 13%.

#### **Florida Compared to National Data**

- In 2010, the average number of provider procedures per claim in Florida was 101.7, while the national average (without Florida) was only 47. The average number of procedures per claim in Florida increased from 67.3 in 2007 to its current 2010 level of 101.7.
- In 2010, the average level of provider charges per claim in Florida was \$12,539, while the national average (without Florida) was only \$8,022.

#### ***Affordability/PIP Premium Increases***

The premiums that an automobile insurance carrier is authorized to charge are governed under s. 627.0651, F.S., which specifies that OIR must consider “[p]ast and prospective loss experience” when establishing a carrier's authorized rates. Accordingly, as the claim costs for PIP continue to rise, those increases will necessarily drive a corresponding increase in the premiums that must be paid by Florida's insurance consumers. Not surprisingly, then, recent premium trends are following the same pattern of increase as the claim costs.

At the August 16, 2011, Cabinet meeting, Insurance Commissioner Kevin McCarty presented rate increase data for the top 5 automobile insurance insurers. The 5 insurers represented 42.5% of the automobile insurance market, and the data presented the amount of rate increase that had been implemented from January 1, 2009 and August 1, 2011. Over this nineteen month period, the 5 insurers implemented respective average PIP increases of: State Farm Mutual Automobile Insurance Company 49.7%; GEICO General Insurance Company 72.2%; Progressive American Insurance Company 63.0%; Progressive Select Insurance Company 48.5%; Allstate Insurance Company 35.1%.

Representatives of OIR anticipate this trend will continue under the current circumstances.

### *2011 Proposed Legislation*

During the 2011 Legislative Session, proposals seeking to address some of the elements raised in this brief were discussed and debated as the subject of several bills that did not pass.<sup>8</sup> Some of the proposals went through more than one iteration and were contained in more than one bill, covering major topics that include:

1. Limiting the plaintiff's attorney fees in a no-fault dispute to the lesser of \$10,000 or three times the amount recovered, with a class action limit of the lesser of \$50,000 or three times the recovery.

Proponents of this provision argue that often an award of attorney fees can be excessive, even when the actual damage suffered by the PIP plaintiff is nominal, thus defying the central purpose of a no-fault system that was designed to be self-effecting in order to avoid high legal costs associated with an at-fault system. Opponents argue that often the only way for a plaintiff to obtain legal representation to sue an intransigent insurer is to allow full recovery of the plaintiff's legal fees.

2. Prohibiting the use of a contingency risk multiplier to calculate the attorney's fees recovered under the no-fault law.

Proponents of this provision argue that the purpose of a contingency risk multiplier is to encourage an attorney to be willing to take a high risk case of particular complexity, but the multiplier is often awarded in simple PIP claims of nominal levels -- circumstances that do not reflect the intent of using a multiplier. Opponents argue that PIP claims often involve very complex issues, in spite of the low claim value, and that courts seldom apply the multiplier under current law.

3. Authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider, and with the provision that the insured forfeits the premium discount upon using a non-network provider for non-emergency services if there are qualified network providers within 15 miles of the insured's residence. Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" (PPO) option, but if the insured uses an "out-of-network" provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law.

Proponents of this provision argue that this would allow the consumer to choose whether to buy a less expensive product that has some restriction on the provider network that is available after an accident, or to buy a more expensive product that has no provider restriction after an accident. Opponents argue that consumers could be induced by low premiums to buy a product that would not meet their medical needs after an accident.

4. Authorizing insurers to offer motor vehicle insurance policies that allow the insurer or claimant to demand arbitration of claims disputes over PIP benefits.

Proponents of this provision argue that this would allow for a more expeditious and inexpensive process for the resolution of PIP disputes. Opponents argue that often the controversy in question is of a legal nature, which does not lend itself to proper resolution through the arbitration process.

5. Revising several provisions related to demand letters:
  - The claimant filing suit must submit the demand letter.
  - A demand letter that does not meet the statutory requirements is defective.
  - A demand letter cannot be used to request record production from the insurer.
  - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect.

---

<sup>8</sup> See: SB 1694 by Senator Richter; SB 1930 by Senator Bogdanoff; HB 967 by Representatives Horner and Boyd; and HB 1411 by Representative Boyd.

Proponents of these provisions argue that requiring greater specificity to perfect a demand letter would better able insurers to obtain the level of detail necessary to make an informed decision on whether to dispute the claim. Opponents argue that this is unnecessary because an insurer can refuse to pay a demand when a demand letter does not justify payment, requiring the claimant to sue, whereby the insurer would be able to obtain detailed information through discovery.

6. Requiring the insured and any medical provider that accepts an assignment of no-fault benefits from the insured to comply with all terms of the policy, including submitting to an examination under oath (EUO).

Medical providers and insurers dispute whether a medical provider who has accepted an assignment of benefits may be required by the insurer to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,<sup>9</sup> that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. Proponents argue that often only the medical provider has the expertise to answer the questions necessary to determine whether the full amount of a claim should be paid, and when the provider is assigned benefits, that provider should be required to adhere to the contractual obligation to submit to an EUO. Opponents argue that the information necessary to determine payment is already available to the insurer through medical documentation, and that this provision, as proposed, could be abused by insurers to harass and unduly encroach on the time that a provider could be spending to treat patients.

7. Clarifying that the Medicare fee schedule in effect of January 1 of a given year will be the schedule that controls throughout that year for determining the proper PIP fee schedule to be applied for an accident that occurs during that calendar year.

Currently, Section 627.736(5), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to a specified percentage of the Medicare schedule, with variations depending on the specific medical service rendered. The payments cannot go below the 2007 Medicare levels, but the payments are to reflect any increases that have been made to the 2007 Medicare levels. Insurers state that because Medicare changes its schedule periodically throughout the year, there is often confusion as to the proper Medicare fee schedule to apply, resulting in unintended disputes over minor differences. Proponents believe this confusion will be relieved by tying the PIP payment to the Medicare fee schedule in effect as of January 1 of a given year (not to go below the 2007 Medicare schedule).

8. Prohibiting a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act.

Insurers believe this provision would be a significant deterrent to claimants who otherwise might contemplate submitting false or misleading information. Opponents are concerned about the possibility of extreme consequences when the claimant unintentionally submits questionable information.

9. Increasing the civil penalties (fines) that can be levied on perpetrators of insurance fraud, and requiring suspension of an occupational license or a health care practitioner license for any person convicted of insurance fraud.

Proponents argue that these provisions will be a further deterrent to individuals who otherwise contemplate committing acts of insurance fraud. Opponents have expressed some concern over the implementation of some of the provisions that were proposed.

10. Creating a rebuttable presumption that the injured party's failure to appear for a mental or physical examination was unreasonable.

---

<sup>9</sup> *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Insurers have complained that they are often stymied by claimants' continued failure to appear for the examination that the insurer must conduct to determine whether they dispute the claim in question. Opponents fear that, unless qualified, this provision could be abused by insurers to establish an inconvenient time that the claimant would not be able to attend.

11. Authorizing an insurer to conduct an on-site physical review and examination of the treatment location.

Proponents of this provision argue that this would allow an insurer to ascertain that a clinic or other treatment facility actually possessed the equipment (MRI, X-ray, etc.) necessary to perform the testing and treatment being claimed, and to expose sham facilities. Opponents fear that this provision, unless qualified, could be abused by an insurer to intimidate or inconvenience legitimate operations.

12. Prohibiting a claimant from filing a lawsuit until the claimant complies with the insurer's investigation.

Proponents of this provision argue that this provision would help to resolve those cases where there ultimately is no dispute, before expensive litigation costs are added into the equation. Opponents believe this provision would be abused by some insurers to draw out the process and avoid paying legitimate claims.