By Senator Kurth

15-1115A-98 See HB

A bill to be entitled

An act relating to insurance fraud; amending s. 440.09, F.S.; conforming references to judges of compensation claims and administrative law judges; amending s. 440.105, F.S.; specifying a schedule of criminal penalties for certain prohibited activities; providing definitions; providing a period of limitations for undertaking certain proceedings; amending s. 624.416, F.S.; providing additional criteria for the Department of Insurance to consider in issuing certain certificates of authority; amending s. 624.418, F.S.; providing an additional criterion for suspending or revoking certain certificates of authority; amending s. 626.989, F.S.; providing for reports of insurance fraud to the Division of Insurance Fraud of the Department of Insurance; amending s. 626.9891, F.S.; requiring insurers to provide for investigation of fraudulent claims; requiring insurers to adopt an anti-fraud plan; providing criteria and procedures; requiring insurers to file an anti-fraud report with the department; specifying contents; authorizing the department to adopt rules; creating s. 626.9892, F.S.; establishing the Anti-Fraud Reward Program in the department; providing for awarding rewards under certain circumstances; exempting certain department actions from Florida Administrative Code requirements; amending s. 627.062, F.S.; requiring the

department to consider certain additional factors in reviewing rate filings; amending s. 627.072, F.S.; requiring consideration of certain additional factors in making and using rates; amending s. 627.411, F.S.; requiring the department to consider certain additional factors in determining the reasonableness of benefits in relation to premium charges; amending s. 641.31, F.S.; providing for disapproval of rates, forms, or other filings; creating s. 641.3915, F.S.; requiring certain health maintenance organizations to provide for investigation of fraudulent claims; requiring health maintenance organizations to adopt an anti-fraud plan; providing criteria and procedures; requiring health maintenance organizations to file an anti-fraud report with the department; specifying contents; authorizing the department to adopt rules; amending s. 817.234, F.S.; specifying a schedule of criminal penalties for committing insurance fraud or insurance solicitation; providing definitions; providing a period of limitations for undertaking certain proceedings; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 440.09, Florida Statutes, is amended to read:

440.09 Coverage.--

(4) An employee shall not be entitled to compensation or benefits under this chapter if any judge of compensation claims, administrative law judge ~~hearing officer~~, court, or jury convened in this state determines that the employee has knowingly or intentionally engaged in any of the acts described in s. 440.105 for the purpose of securing workers' compensation benefits.

Section 2. Subsections (4) and (6) of section 440.105, Florida Statutes, are amended, and subsection (8) is added to said section, to read:

440.105 Prohibited activities; penalties; limitations.--

(4)(a) Whoever violates any provision of this subsection commits insurance fraud. If the value of any property involved in violation of this subsection:

1. Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b)~~(a)~~ It shall be unlawful for any employer to knowingly:

1. Present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

2. Make a deduction from the pay of any employee entitled to the benefits of this chapter for the purpose of requiring the employee to pay any portion of premium paid by the employer to a carrier or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by this chapter.

3. Fail to secure payment of compensation if required to do so by this chapter.

(c)~~(b)~~ It shall be unlawful for any person:

1. To knowingly make, or cause to be made, any false, fraudulent, or misleading oral or written statement for the purpose of obtaining or denying any benefit or payment under this chapter.

2. To present or cause to be presented any written or oral statement as part of, or in support of, a claim for payment or ~~of~~ other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

3. To prepare or cause to be prepared any written or oral statement that is intended to be presented to any employer, insurance company, or self-insured program in connection with, or in support of, any claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

4. To knowingly assist, conspire with, or urge any person to engage in activity prohibited by this section.

5. To knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information, required by s. 440.185 or s. 440.381, for the purpose of obtaining workers' compensation coverage or for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums.

6. To knowingly misrepresent or conceal payroll, classification of workers, or information regarding an employer's loss history which would be material to the computation and application of an experience rating modification factor for the purpose of avoiding or diminishing the amount of payment of any workers' compensation premiums.

7. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

(d)~~(c)~~ It shall be unlawful for any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, optometric physician licensed under chapter 463, or any other practitioner licensed under the laws of this state to knowingly and willfully assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(e)~~(d)~~ It shall be unlawful for any person or governmental entity licensed under chapter 395 to maintain or operate a hospital in such a manner so that such person or governmental entity knowingly and willfully allows the use of the facilities of such hospital by any person, in a scheme or

conspiracy to fraudulently violate any of the provisions of this chapter.

(f)~~(e)~~ It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or any firm, corporation, partnership, or association, to knowingly assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(g)~~(f)~~ It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee or for any firm, corporation, partnership, or association, to unlawfully solicit any business in and about city or county hospitals, courts, or any public institution or public place; in and about private hospitals or sanitariums; in and about any private institution; or upon private property of any character whatsoever for the purpose of making workers' compensation claims.

(6) For the purpose of the section:~~, the term~~

(a) "Statement" includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor records, X ray, test result, or other evidence of loss, injury, or expense.

(b) "Property" means property as defined in s. 812.012.

(c) "Value" means value as defined in s. 812.012.

(8) Notwithstanding any other provision of law, a proceeding under subsection (4) may be commenced at any time within 5 years after the cause of action accrues; however, in such proceeding, the period of limitation is tolled whenever

the defendant is continuously absent from this state or is without a reasonably ascertainable place of residence or work within this state, but not to extend such period of limitation by more than 1 year. If a criminal prosecution, action, or other proceeding is brought, or intervened in, to punish, prevent, or restrain any violation of subsection (4), the running of the period of limitation prescribed by this section, which is based in whole or in part upon any matter complained of in any such prosecution, action, or proceeding, shall be tolled during the pendency of the prosecution, action, or proceeding and for 2 years following the termination of such prosecution, action, or proceeding.

Section 3. Subsection (4) of section 624.416, Florida Statutes, is amended to read:

624.416 Continuance, expiration, reinstatement, and amendment of certificate of authority.--

(4) The department may amend a certificate of authority at any time to accord with changes in the insurer's charter or insuring powers. Prior to amending an existing certificate of authority to authorize an insurer to transact a new line of business, the department shall require the applicant to demonstrate compliance with the provisions of s. 626.9891 and to allocate sufficient resources to identify and eliminate fraud. The department shall consider the extent of such resources in determining whether to authorize an insurer to transact a new line of business.

Section 4. Subsection (1) of section 624.418, Florida Statutes, is amended to read:

624.418 Suspension, revocation of certificate of authority for violations and special grounds.--

(1) The department shall suspend or revoke an insurer's certificate of authority if it finds that the insurer:

(a) Is in unsound financial condition.

(b) Is using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.

(c) Has failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final.

(d) Has failed to comply with the requirements of s. 626.9891 or has failed to allocate sufficient resources to identify and eliminate fraud.

(e)~~(d)~~ No longer meets the requirements for the authority originally granted.

Section 5. Subsection (6) of section 626.989, Florida Statutes, is amended to read:

626.989 Division of Insurance Fraud; definition; investigative, subpoena powers; protection from civil liability; reports to division; division investigator's power to execute warrants and make arrests.--

(6) Any person, other than an insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, under s. 440.105, or under s. 817.234, is being or has been committed may send to the Division of Insurance Fraud a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may request.

Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, under s. 440.105,or under s. 817.234, is being or has been committed shall send to the Division of Insurance Fraud a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require. The Division of Insurance Fraud shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, under s. 440.105,or under s. 817.234, is being committed. The Division of Insurance Fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction with respect to any such violation, as provided in s. 624.310. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the division's report, the state attorney or other prosecuting agency having

jurisdiction with respect to such violation shall inform the division of the reasons for the lack of prosecution.

Section 6. Section 626.9891, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 626.9891, F.S., for present text.)

626.9891 Insurer anti-fraud plans, reports, and investigative units.--

(1) Each authorized insurer that had $10 million or more in direct premiums written during the previous calendar year shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or

(b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds.

For purposes of this section, the term "unit or division" includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.

(2)(a) Each authorized insurer shall adopt an anti-fraud plan, which shall be filed with the department prior to January 1, 1999.

(b) Any insurer that previously filed an anti-fraud plan with the department shall amend the plan to comply with the requirements of subsection (3) and shall file all plan amendments with the department prior to January 1, 1999.

(c) Any insurer that files an application for a certificate of authority with the department prior to January 1, 1999, shall, if the certificate is not issued as of that date, comply with the requirements of this section within 90 days after the issuance of a certificate of authority.

(d) Any insurer that files an application for a certificate of authority with the department on or after January 1, 1999, shall comply with the requirements of this section when the application is filed.

(3) Each insurer's anti-fraud plan shall include:

(a) A description of the unit or division established, or a copy of the contract and related documents required under subsection (1), if applicable.

(b) A description of the insurer's policies and procedures that facilitate the detection and investigation of possible fraudulent insurance acts, including specific policy provisions and investigative procedures intended to combat complex instances of fraud with respect to each of the following coverages: health, property, casualty, and workers' compensation and employer's liability.

(c) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the department.

(d) A description of the insurer's procedures for auditing workers' compensation insureds to verify covered employees and to ensure proper classification, loss experience reporting, and premium collection practices.

(e) A description of the insurer's anti-fraud education and training program for claims adjusters or other personnel.

(f) A description or chart that includes the organizational arrangement of the insurer's anti-fraud personnel and the education, training, and claims adjusting, law enforcement, or other investigative experience of such personnel responsible for the investigation of possible fraudulent insurance acts.

(4) Each insurer shall file an anti-fraud report with the department prior to March 1, 2000, and annually thereafter, which shall include, for the previous calendar year:

(a) Material changes or amendments to personnel, policies, or procedures in the insurer's anti-fraud plan.

(b) A summary of significant actions taken by the insurer to combat or prosecute cases of insurance fraud and cases of workers' compensation insurance premium fraud.

(c) A statement of the insurer's actual or estimated losses in this state due to fraudulent insurance claims, by line of coverage, and the increase or decrease in such losses compared to previous calendar years.

(d) The amount of direct premiums written, by line of coverage, in the previous calendar year and the number of fraud referrals, by line of coverage, made by the insurer to the department during the reporting period.

(5) The department may recommend changes or amendments to an insurer's anti-fraud plan.

(6) The department may adopt any rules necessary to implement the provisions of this section.

Section 7. Section 626.9892, Florida Statutes, is created to read:

626.9892 Anti-Fraud Reward Program; reporting of insurance fraud.--

(1) The Anti-Fraud Reward Program is hereby established within the department, to be funded from the Insurance Commissioner's Regulatory Trust Fund.

(2) The department may, at its discretion, pay rewards of up to $25,000 to persons responsible for providing information leading to the arrest and conviction of persons committing complex and organized crimes, investigated by the Division of Insurance Fraud, arising from violations of the insurance code, s. 440.105, or s. 817.234.

(3) Only a single reward amount may be awarded for each case, regardless of the number of persons arrested and convicted in connection with the case and regardless of how many persons submit claims for the reward.

(4) The department shall establish procedures to implement and administer the Anti-Fraud Reward Program. Applications for rewards authorized by this section must be made pursuant to the procedures established by the department.

(5) All determinations and other actions of the department pursuant to this section are exempt from the provisions of chapter 120.

Section 8. Paragraph (b) of subsection (2) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.--

(2) As to all such classes of insurance:

(b) Upon receiving a rate filing, the department shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that

determination, the department shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The department may promulgate rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used in the calculation of insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus shall not be considered. The profit and contingency factor as specified in the filing shall be utilized in computing excess profits in conjunction with s. 627.0625.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. A reasonable margin for underwriting profit and contingencies.

12. The cost of medical services, if applicable.

13. Compliance with the requirements of s. 626.9891 and the allocation of sufficient resources to identify and eliminate fraud.

14.~~13.~~ Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

Section 9. Subsection (1) of section 627.072, Florida Statutes, is amended to read:

627.072 Making and use of rates.--

(1) As to workers' compensation and employer's liability insurance, the following factors shall be used in the determination and fixing of rates:

(a) The past loss experience and prospective loss experience within and outside this state;

(b) The conflagration and catastrophe hazards;

(c) A reasonable margin for underwriting profit and contingencies;

(d) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) Investment income on unearned premium reserves and loss reserves;

(f) Past expenses and prospective expenses, both those countrywide and those specifically applicable to this state; ~~and~~

(g) Compliance with the requirements of s. 626.9891 and the allocation of sufficient resources to identify and eliminate fraud; and

(h)~~(g)~~ All other relevant factors, including judgment factors, within and outside this state.

Section 10. Paragraph (e) is added to subsection (2) of section 627.411, Florida Statutes, to read:

627.411 Grounds for disapproval.--

(2) In determining whether the benefits are reasonable in relation to the premium charged, the department, in accordance with reasonable actuarial techniques, shall consider:

(e) Compliance with the requirements of s. 626.9891 and the allocation of sufficient resources to identify and eliminate fraud.

Section 11. Paragraph (d) is added to subsection (3) of section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(3)

(d) The department shall withdraw or withhold approval of any health maintenance organization rate, form, or other filing required under this subsection if the department determines that the health maintenance organization has not

complied with the requirements of s. 641.3915 or has not allocated sufficient resources to identify and eliminate fraud.

Section 12. Section 641.3915, Florida Statutes, is created to read:

641.3915 Health maintenance organization anti-fraud plans, reports, and investigative units.--

(1) Each authorized health maintenance organization that had $10 million or more in revenues during the previous calendar year shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by subscribers or by persons making claims for services against policies held by subscribers; or

(b) Contract with others to investigate possible fraudulent claims for services against policies held by subscribers.

For purposes of this section, the term "unit or division" includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. If a health maintenance organization creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred shall be included as an administrative expense for ratemaking purposes.

(2)(a) Each authorized health maintenance organization must adopt an anti-fraud plan and file it with the department before January 1, 1999.

(b) Any health maintenance organization that has filed an application for a certificate of authority with the department prior to January 1, 1999, shall, if the certificate is not issued as of that date, comply with the requirements of this section within 90 days after the issuance of the certificate of authority.

(c) Any health maintenance organization that files an application for a certificate of authority with the department on or after January 1, 1999, shall comply with the requirements of this section when the application is filed.

(3) Each health maintenance organization's anti-fraud plan shall include:

(a) A description of the unit or division established, or a copy of the contract and related documents required under subsection (1), if applicable.

(b) A description of the health maintenance organization's policies and procedures that facilitate the detection and investigation of possible fraudulent insurance acts.

(c) A description of the health maintenance organization's procedures for the mandatory reporting of possible fraudulent insurance acts to the department.

(d) A description of the health maintenance organization's anti-fraud education and training program for claims adjusters or other personnel.

(e) A description or chart that includes the organizational arrangement of the health maintenance organization's anti-fraud personnel and the education, training, and claims adjusting, law enforcement, or other investigative experience of such personnel responsible for the investigation of fraudulent insurance acts.

(4) Each health maintenance organization shall file an anti-fraud report with the department before March 1, 2000, and annually thereafter, which shall include, for the previous calendar year:

(a) Material changes or amendments to personnel, policies, or procedures in the health maintenance organization's anti-fraud plan.

(b) A summary of significant actions taken by the health maintenance organization to combat or prosecute cases of insurance fraud.

(c) A statement of the health maintenance organization's actual or estimated losses in this state due to fraudulent claims and the increase or decrease in such losses compared to previous calendar years.

(d) The number of fraud referrals made by the health maintenance organization to the department during the reporting period.

(5) The department may recommend changes or amendments to a health maintenance organization's anti-fraud plan.

(6) The department may adopt any rules necessary to implement the provisions of this section.

Section 13. Subsections (1), (2), (3), (4), (8), and (9) of section 817.234, Florida Statutes, are amended, and subsections (11), (12), and (13) are added to said section, to read:

817.234 False and fraudulent insurance claims.--

(1)(a) Any person who, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy,

knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; or

3. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or who conceals information concerning any fact material to such application,

commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(b) All claims and application forms shall contain a statement that is approved by the Department of Insurance that clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree." The changes in this paragraph relating to applications shall take effect on March 1, 1996.

(2) Any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractor licensed under chapter 460, or other practitioner licensed under the laws of this state who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractor, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~is guilty of a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. In the event that a physician, osteopathic physician, chiropractor, or practitioner is adjudicated guilty of a violation of this section, the Board of Medicine as set forth in chapter 458, the Board of Osteopathic Medicine as set forth in chapter 459, the Board of Chiropractic as set forth in chapter 460, or other appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopathic physician, chiropractor, or practitioner.

(3) Any attorney who knowingly and willfully assists, conspires with, or urges any claimant to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging on such attorney's part, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~a felony of the third degree~~,

punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(4) Any ~~No~~ person or governmental unit licensed under chapter 395 to maintain or operate a hospital, and any ~~no~~ administrator or employee of any such hospital, who ~~shall~~ knowingly and willfully allows ~~allow~~ the use of the facilities of said hospital by an insured party in a scheme or conspiracy to fraudulently violate any of the provisions of this section or part XI of chapter 627~~. Any hospital administrator or employee who violates this subsection~~ commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. Any adjudication of guilt for a violation of this subsection, or the use of business practices demonstrating a pattern indicating that the spirit of the law set forth in this section or part XI of chapter 627 is not being followed, shall be grounds for suspension or revocation of the license to operate the hospital or the imposition of an administrative penalty of up to $5,000 by the licensing agency, as set forth in chapter 395.

(8) It is unlawful for any person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association, to solicit any business in or about city receiving hospitals, city and county receiving hospitals, county hospitals, justice courts, or municipal courts; in any public institution; in any public place; upon any public street or highway; in or about private hospitals, sanitariums, or any private institution; or upon private property of any character whatsoever for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits

required by s. 627.736. Any person who violates the provisions of this subsection commits insurance solicitation ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(9) It is unlawful for any attorney to solicit any business relating to the representation of persons injured in a motor vehicle accident for the purpose of filing a motor vehicle tort claim or a claim for personal injury protection benefits required by s. 627.736. The solicitation by advertising of any business by an attorney relating to the representation of a person injured in a specific motor vehicle accident is prohibited by this section. Any attorney who violates the provisions of this subsection commits insurance solicitation ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney is guilty of a violation of this section, such committee shall forward to the appropriate state attorney a copy of the finding of probable cause and the report being filed in the matter. This section shall not be interpreted to prohibit advertising by attorneys which does not entail a solicitation as described in this subsection and which is permitted by the rules regulating The Florida Bar as promulgated by the Florida Supreme Court.

(11) If the value of any property involved in violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(12) As used in this section:

(a) "Property" means property as defined in s. 812.012.

(b) "Value" means value as defined in s. 812.012.

(13) Notwithstanding any other provision of law, a proceeding under this section may be commenced at any time within 5 years after the cause of action accrues; however, in such proceeding, the period of limitation is tolled whenever the defendant is continuously absent from this state or is without a reasonably ascertainable place of residence or work within this state, but not to extend such period of limitation by more than 1 year. If a criminal prosecution, action, or other proceeding is brought, or intervened in, to punish, prevent, or restrain any violation of this section, the running of the period of limitation prescribed by this section, which is based in whole or in part upon any matter complained of in any such prosecution, action, or proceeding, shall be tolled during the pendency of the prosecution, action, or proceeding and for 2 years following the termination of such prosecution, action, or proceeding.

Section 14. The sum of $250,000 is hereby appropriated from the Insurance Commissioner's Regulatory Trust Fund in a nonoperating category to implement the purpose and provisions of funding the anti-fraud reward program established by this act.

Section 15. This act shall take effect upon becoming a law.

****

LEGISLATIVE SUMMARY

Requires insurers and health maintenance organizations to provide for investigating insurance fraud and to submit anti-fraud plans to the division. Establishes penalty levels and prescribes time limitations for prosecution of prohibited insurance fraud and solicitations. Provides for disapproval of rates, forms, and filings.