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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH REGULATION
ANALYSIS

BILL #: CS/HB 1819 (PCB IN 01-03)

RELATING TO: Insurance/Public Records Illegal Use

SPONSOR(S): Committee on Health Regulation, Committee on Insurance, Representative Waters and others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) INSURANCE YEAS 14 NAYS 0
(2) HEALTH REGULATION YEAS 10 NAYS 0
(3) COUNCIL FOR SMARTER GOVERNMENT
(4)
(5)

I. SUMMARY:

Under the Florida Motor Vehicle No-Fault law, motor vehicle owners are required to maintain $10,000 of personal injury protection coverage. Personal injury protection coverage covers the vehicle owner, relatives residing in the same household, passengers or pedestrians involved in the motor vehicle accident who do not have their own personal injury protection coverage, and persons driving the vehicle with the owner's permission.

The second interim report of the Fifteenth Statewide Grand Jury, released in September 2000, examined insurance fraud related to personal injury protection and made 7 recommendations to the Legislature.

CS/HB 1819 makes a number of changes in response to the concerns raised by the Grand Jury, including:

- Increasing penalties for using information in police reports for commercial solicitation of crime or accident victims to a third degree felony.
- Requiring certain clinics to register with the Department of Health and employ a medical director.
- Defining "medically necessary" as used in the motor vehicle no-fault law.
- Eliminating payments for "spiritual healing" as a personal injury protection benefit.
- Changing the interest rate for overdue payments to an indexed rate.
- Adding additional diagnostic tests to those now subject to the fee schedule and limiting the maximum reimbursement for certain magnetic resonance imaging services to 75 percent of the Ingenix Fee Analyzer.
- Requiring notice be sent to the insurer before a nonpayment or late payment action could be brought against the insurer.
- Creating a cause of action for insurers to recover damages and attorney's fees against persons convicted of insurance fraud or patient brokering.

The bill appropriates $100,000 and one-half of one full-time equivalent position to the Department of Health for purposes of regulating medical clinics.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [X] N/A []

Clinics owned by persons other than licensed physicians and not otherwise licensed under Florida law would be required to register with the Department of Health and employ a medical director.

2. Lower Taxes Yes [] No [] N/A [X]

3. Individual Freedom Yes [] No [X] N/A []

Clinics owned by persons other than licensed physicians and not otherwise licensed under Florida law would be required to register with the Department of Health and employ a medical director.

4. Personal Responsibility Yes [] No [] N/A [X]

5. Family Empowerment Yes [] No [] N/A [X]

B. PRESENT SITUATION:

Florida's No-fault Law

Background
The Legislature enacted Florida's "no-fault" insurance law in 1971. Under the Florida Motor Vehicle No-Fault law,[1] motor vehicle owners are required to maintain $10,000 of personal injury protection coverage. Personal injury protection covers the vehicle owner, relatives residing in the same household, passengers or pedestrians involved in the motor vehicle accident who do not have their own personal injury protection coverage, and persons driving the vehicle with the owner's permission.

Those with personal injury protection coverage receive limited immunity from tort liability for damages to the extent the economic loss is compensated under the personal injury protection policy. This limited immunity protects against non-economic damages, such as pain and suffering. However, immunity does not extend to injuries consisting of: (1) significant and permanent loss of an important bodily functions; (2) permanent injury within a reasonable degree of medical probability (other than scarring or disfigurement); (3) significant and permanent scarring or disfigurement; or (4) death. In short, a plaintiff must suffer a permanent injury in order to seek pain and suffering damages against a motorist with personal injury protection coverage.

The stated purpose of the no-fault law, as set forth in s. 627.731, F.S., is to:

> "provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles required to be

[1] Sections 627.730-627.745, Florida Statutes

registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience."

Benefits Available

With respect to injuries sustained in a motor vehicle accident, regardless of who is at fault, a vehicle owner's personal injury protection coverage will generally pay 80 percent of medical costs, and 60 percent of lost wages and similar costs, up to a limit of $10,000. Personal injury protection insurance also will pay up to a $5,000 death benefit.

Payment of Claims

To receive payment, health care providers are required to submit medical bills directly to insurers within 30 days of the date of treatment. If the medical provider notifies the insurer within 21 days after first examination or treatment, the provider may submit medical bills within 60 days of the date of treatment. Neither the insurer nor the injured person is required to pay medical bills that are not submitted within this time frame and any agreement to the contrary is unenforceable. Exceptions to this requirement are provided for medical services billed by a hospital for services rendered at a hospital-owned facility, for emergency services rendered by a hospital emergency department, or transport and treatment rendered by an ambulance provider.

Overdue Payment of Benefits

Personal injury protection benefits are considered overdue if not paid by the insurer within 30 days after the insurer is billed for such charges. Payments are not considered to be overdue if the insurer has "reasonable proof to establish" that it is not responsible for the claim. An insurer is required to pay simple interest of 10 percent on any overdue claim. A person filing a suit against an insurer for an overdue claim is not required to notify the insurer of the overdue claim prior to filing suit. If the insurer does not prevail in the case of an overdue claim, the insurer can be liable for the amount of the claim, interest on the overdue claim, and the claimant's attorney's fees.

In 1999, the Third District Court of Appeal held in *Perez v. State Farm Fire and Casualty Company*, 746 So.2d 1123 (Fla. 3rd DCA 1999), that the PIP statute requires the insurer to obtain "reasonable proof" that it is not responsible for payment within 30 days. In *Perez*, the 3rd DCA held that the insurer failed to obtain such proof within 30 days and, regardless of whether the claim was unreasonable, unrelated, or not medically necessary, the insurer was responsible for the claim plus interest.

Charges for Treatment

Physicians, hospitals, clinics, or other persons may charge only a *reasonable* amount for products, services, and accommodations rendered. Physicians, hospitals, clinics, or other persons may not charge more than they customarily charge a person lacking insurance. Only charges for thermograms are limited to the maximum reimbursement allowance set forth for workers' compensation.[2]

The federal Medicare program utilizes a fee schedule, limiting the maximum allowable reimbursement for specified services. Medicare Part B generally covers doctor's bills, outpatient hospital care, and some preventive care. According to the Department of Insurance, a magnetic resonance imaging test of an arm would be reimbursed $604 under the workers' compensation fee schedule set forth in s. 440.13, F.S., and an average of $966 under Medicare Part B. The Ingenix Custom Fee Analyzer is a fee schedule developed by Ingenix, health data and information company, for use by health care providers.

[2] Section 440.13, Florida Statutes

Licensing and Regulation of Health Care Professions and Facilities

Health Care Professions
Chapter 456, Florida Statutes, sets forth the general provisions for licensure of health professions and occupations. This chapter also sets forth the organization of the various practice boards. Additionally, Chapter 456 describes the penalties for certain violations and sets forth the proceedings for disciplinary actions.

In addition to Chapter 456, four physician groups also are regulated under separate chapters of the Florida Statutes. These chapters are:

- Chapter 458, regulating medical doctors and establishing the Board of Medicine;
- Chapter 459, regulating osteopathic physicians and establishing the Board of Osteopathic Medicine;
- Chapter 460, regulating chiropractic physicians and establishing the Board of Chiropractic Medicine; and
- Chapter 461, regulating podiatric medicine and establishing the Board of Podiatric Medicine.

Health Care Facilities
Not all health care facilities are required to be licensed or registered by the state. However, certain medical facilities are required to be licensed or registered by the state under chapters 383, 390, 393, 394, 395, 400,and 483, F.S., including abortion clinics, hospital, and ambulatory surgical centers under the Agency for Health Care Administration, and facilities licensed by the Department of Health, including optometry branch offices, optical establishments, mental health facilities, pharmacies, dental laboratories, electrolysis facilities, and massage establishments.

Insurance Fraud Related to Personal Injury Protection Insurance

Grand Jury Findings
The Fifteenth Statewide Grand Jury issued a report in September 2000, examining insurance fraud related to personal injury protection coverage. The Statewide Grand Jury defined fraud as: the illegal solicitation of accident victims for the purpose of filing for personal injury protection benefits and motor vehicle tort claims; brokering patients between doctors, lawyers and diagnostic facilities; billing insurers for treatment not rendered; using phony diagnostic tests or misusing legitimate tests; inflating charges for diagnostic tests or procedures; and filing fraudulent motor vehicle tort lawsuits. According to the Grand Jury, "certain people have turned the $10,000 of personal injury protection coverage into their own personal slush fund."

SOLICITATION AND ACCIDENT REPORTS
The Grand Jury found that individuals called "runners" collect accident reports, which are public records, from law enforcement agencies and use the information to solicit persons involved in accidents or give the information to another person who solicits the victims. Other runners, according to the Grand Jury, print the information in "accident journals" sold to medical providers and attorneys who solicit persons involved in accidents.

Subsection (8) of s. 817.234, F.S., prohibits anyone from soliciting business for the purpose of making motor vehicle tort claims or personal injury protection benefit claims. Subsection (9) of s. 817.234, F.S., similarly prohibits attorneys from soliciting persons injured in motor vehicle accidents for the purpose of making motor vehicle tort claims or personal injury protection benefit claims. A

solicitation prohibited by s. 817.234 (8) and (9), F.S., is a third degree felony. The Florida Bar also regulates advertisements and solicitations by attorneys.[3]

The Florida Supreme Court has been asked to decide two issues regarding subsection (8) of s. 817.234, F.S.:

1) whether subsection (8) of s. 817.234, F.S., requires an intent to defraud as an element of the crime?

The Fourth District Court of Appeal[4] has alternately found that the statute does not require the intent to defraud when soliciting motor vehicle crash victims. The Third District Court of Appeal[5] has relied upon earlier Fourth District cases finding that intent to defraud is required.

2) whether subsection (8) of s. 817.234, F.S., is sufficiently "narrowly tailored" to pass constitutional muster?

The First District Court of Appeal[6] has found subsection (8) of s. 817.234, F.S., unconstitutional. The First District reasoned that the subsection is not "narrowly tailored" to the advancement of a substantial state interest. Conversely, the Fourth District, applying the same test as the First District, has found this subsection constitutional. The First District has certified the conflict between the First and Fourth Districts on the issue of constitutionality to the Supreme Court.[7]

DIAGNOSTIC TESTS AND BROKERING

Individuals are generally given a variety of diagnostic tests, characterized by the Grand Jury as "extremely profitable tests of marginal utility or validity," such as nerve conduction studies or video fluoroscopy.

The brokering of certain medical tests also concerned the Grand Jury. Individuals have formed magnetic resonance imaging brokerage businesses, which negotiate deals with magnetic resonance imaging facilities to perform magnetic resonance imaging tests and then bill out these same tests to an insurance company for more than the test actually costs.

Personal injury protection claims must be paid within 30 days or the claim is considered overdue and the insurer will be liable in a suit to recover these personal injury protection benefits. The company will also be responsible for paying a plaintiff's legal fees, which can add thousands to the amount of the settlement, according to the Grand Jury.

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[3] In addition to criminal penalties provided by statute, attorneys are prohibited from soliciting clients "when a significant motive for the lawyer's doing so is the lawyer's pecuniary gain." Further, attorneys are prohibited from making written solicitations of accident and natural disaster victims concerning claims for personal injury or wrongful death within 30 days of the accident or natural disaster. See Rule 4-7.4, Rules Regulating the Florida Bar.

[4] *Bradford v. State*, 740 So.2d 569 (Fla. 4th DCA 1999) (holding that the subsection does not punish purely innocent activity), and *Hansbrough v. State*, 757 So.2d 1282 (Fla. 4th DCA 2000) (receding from *Bradford)*

[5] *Hershkowitz v. State*, 744 So.2d 1268 (Fla. 3d DCA 1999) (adopting the reasoning of the Fourth District regarding intent to defraud)

[6] *State v. Cronin*, 774 So.2d 871, 26 Fla. L. Weekly D149 (Fla. 1st DCA 2000)

[7] For a discussion of constitutional and other related issues please see Section V. Comments.

The Grand Jury made the following recommendations to the Legislature:

- Amend s. 119.105, F.S., to prohibit the release of accident reports to anyone other than the victim, their insurance company, a radio or TV station licensed by the FCC, or a professional journalist.
- Increase the penalty for violations of s. 119.05, F.S., from a first degree misdemeanor to a third degree felony.
- Require the regulation and licensing of all medical facilities.
- Consider adopting a fee schedule for reimbursement of medical services under the personal injury protection statute
- Give insurers an additional 30 days to pay personal injury protection claims, at least in those instances where the insurer certifies that the claim is being reviewed for possible fraud.
- Make all charges for magnetic resonance imaging tests unenforceable unless the charges are billed and collected by the 100-percent owner or the 100-percent lessee of the equipment used to perform such services.
- Amend s. 817.234(8), F.S., to state that no insurer or auto accident victim is obligated to pay for any services rendered by any medical provider or attorney who has solicited the victim or caused the victim to be solicited contrary to Florida Statutes.

Identification and Enforcement

According to the Division of Insurance Fraud within the Department of Insurance, the Coalition Against Insurance Fraud estimated fraud in Florida's automobile insurance line to be $1.1 billion in 1997, the most recent year for which information is available.

INSURER ANTI-FRAUD UNITS

Since 1996, insurers admitted to do business in Florida have been required to establish and maintain a division or unit to investigate insurance fraud or adopt an anti-fraud plan, depending on the amount of premium written by the insurer. Each insurers anti-fraud plan is required to include a description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts; procedures for the mandatory reporting of possible fraudulent insurance acts to the Department of Insurance; a plan for anti-fraud education and training of its claims adjusters or other personnel; and organizational arrangement of the anti-fraud personnel responsible for the investigation and reporting of possible fraudulent insurance acts.

DIVISION OF INSURANCE FRAUD

The Division of Insurance Fraud employs certified law enforcement officers as investigators with the right to make arrests and bear arms. It is empowered to investigate all violations of the Insurance Code and related criminal statutes.

A total of 5,576 personal injury protection-related referrals involving suspected or actual fraud were reviewed by the Division of Insurance Fraud, and 1,218 criminal investigations resulted from the review of referrals, during the past 5 years. The Division of Insurance Fraud made 643 arrests for personal injury protection-related fraud cases, and 416 convictions were obtained based on these arrests.

STATUTES RELATING TO INSURANCE FRAUD AND SOLICITATION
Florida law prohibits insurance fraud,[8] solicitation,[9] kickbacks,[10] and patient brokering.[11]

C. EFFECT OF PROPOSED CHANGES:

The punishment for using information in police reports for commercial solicitation of crime or accident victims would be increased from a first degree misdemeanor to a third degree felony.

Clinics owned by persons or entities other than licensed physicians would be required to register with the Department of Health, unless the facility is otherwise licensed under Florida law, and employ or contract with a physician to serve as medical director. Any person establishing, operating, or managing an unregistered clinic would commit a third degree felony. Violations by a licensed health care practitioner would be grounds for discipline. Registered clinics could have their registration revoked if found to be in violation of this section.

An insurer or individual eligible for benefits under personal injury protection coverage would not be obligated to pay for services rendered by a medical provider or attorney in any case where the medical provider or attorney has been convicted of solicitation.

CS/HB 1819 defines "medically necessary" for the purpose of the personal injury protection law and makes the following changes to s. 627.736, F.S., to:

- Eliminate payments for "spiritual healing" as a personal injury protection benefit.
- Require all overdue payments bear interest at the rate indexed under s. 55.03, F.S., or the rate set forth in the insurance contract, whichever is greater.
- Permit an insurer to have an additional 30 days from the date the claim would have otherwise been considered overdue if the insurer refers the claim to the Division of Insurance Fraud for investigation.
- Specify that the 30-day period for payment of personal injury protection benefits would not preclude an insurer from challenging a claim as unreasonable, unrelated or not medically necessary.
- Add the following diagnostic tests to those now subject to a maximum reimbursement allowance: spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing.
- Limit the maximum reimbursement for magnetic resonance imaging tests to 75 percent of the Ingenix Customized Fee Analyzer. Hospitals and ambulatory surgical centers would not be subject to the magnetic resonance imaging services fee schedule.
- Require a nonpayment or late payment notice be sent to the insurer before a nonpayment or late payment action could be brought against the insurer. No nonpayment or late payment suit could be brought if the insurer pays the claim along with applicable interest within 7 business days after receipt of the notice.

[8] Section 626.989, Florida Statutes
[9] Section 817.234, Florida Statutes
[10] Section 456.054, Florida Statutes
[11] Section 817.505, Florida Statutes

- Create a cause of action for insurers to recover damages and attorney's fees against a person convicted of insurance fraud or patient brokering.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 119.10, F.S., to increase the punishment for using information in police reports for commercial solicitation of crime or accident victims from a first degree misdemeanor to a third degree felony. Under Florida law, a first degree misdemeanor is punishable by up to one year imprisonment and a fine of up to $1,000. A third degree felony is punishable by up to 5 years imprisonment and a fine of up to $5,000.

Section 2. Creates s. 456.0375, F.S., effective October 1, 2001, to require clinics not owned by a physician licensed under chapters 458, 459, 460, or 461, F.S., to register with the Department of Health, unless the facility is otherwise licensed under Florida law. These clinics also would be required to employ or contract with a physician to be medical director. Each clinic location would be required to register separately. Clinics owned jointly by physicians and their spouses, parents, or children, would not be required to register as long as the physician supervises the services performed at the clinic and is legally responsible.

Registration — Registration requirements would include filing a registration form, which would include the name of the medical director, with the Department of Health and displaying a registration certificate within the clinic. Registration fees would cover the cost of registration and could not exceed the cost to administer and enforce compliance. Registration would be required to be renewed biennially. Facilities such as abortion clinics, mental health facilities, hospitals, optometry branch offices, pharmacies, dental laboratories, electrolysis facilities, massage establishments, ambulatory surgical centers, and similar facilities that are otherwise currently required to be licensed or registered under Florida law would not be required to be registered under this section.

Medical Director — Clinics not owned by licensed physicians would be required to hire a physician with a full and unencumbered license as medical director. Responsibilities of the medical director would include having signs identifying the medical director posted in the clinic which are readily visible to all patients; ensuring all practitioners maintain a current active and unencumbered Florida license; reviewing any patient referral contracts or agreements executed by the clinic; ensuring all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided; serving as the clinic records holder; complying with medical record keeping, office surgery, and adverse incident reporting requirements; and conducting systematic reviews of clinic billings to ensure billings are not fraudulent or unlawful.

Rulemaking Authority —The Department of Health would be given the authority to adopt rules necessary to implement the registration program. Also, the Department of Health would be given rulemaking authority regarding the medical director.

Violations — Any person establishing, operating, or managing an unregistered clinic would commit a third degree felony. Violation of the section by a licensed health care practitioner would be grounds for discipline. Registered clinics could have their registration revoked if found to be in violation of this section. Any claims made by or on behalf of unregistered clinics would be considered to be unlawful charges and be unenforceable.

Section 3. Amends s. 626.989(4)(c), F.S., to expand the provision of immunity from civil liability for individuals reporting suspected insurance fraud pertaining to parties, in addition to acts.

Section 4. Amends s. 627.732, F.S., to include a definition of "medically necessary" for the purposes of the no-fault law. "Medically necessary" would be defined as a medical service or supply a prudent physician would provide for the purposes of treating an illness in a manner that is generally accepted, appropriate, and not for the convenience of the patient or physician.

Section 5. Amends s. 627.736, F.S., to make a number of changes to the personal injury protection statute.

Benefits — The types of medical benefits available under personal injury protection coverage would be amended from "necessary" benefits to "medically necessary" benefits. The benefit for spiritual healing would be removed.

Payment of Claims — An insurer would be allowed an additional 30 days to pay a claim when the claim has been referred to the Department of Insurance for investigation as a fraudulent insurance act, criminal practice, or insurance fraud solicitation. The insurer would be required to notify the person submitting the claim of the referral, unless the Department agreed that notification would compromise the investigation. The expiration of the 30-day period for payment of personal injury protection benefits by an insurer would not preclude an insurer from challenging a claim as unreasonable, unrelated, or not medically necessary.

Overdue Claims — An insurer would be required to pay interest as indexed in s. 55.03, F.S., or the amount in the insurance contract, whichever is greater, rather than a constant rate of 10 percent. The interest rate in s. 55.03, F.S., for 2001 is 11 percent. Section 55.03, Florida Statutes, requires the Comptroller, on December 1 of each year, to set the rate of interest payable on judgments and decrees for the year beginning the following January 1. The Comptroller sets the rate by averaging the discount rate of the Federal Reserve Bank of New York for the preceding year, then adding 500 basis points to the averaged federal discount rate. Additionally, interest would be calculated from the date the insurer was first provided written notice of the claim only for claims referred to the Department of Insurance for investigation, rather than the date at which the claim was overdue, as in current law for all overdue claims.

Fee Schedule — Additional diagnostic tests would be subjected to the fee schedule in the Workers' Compensation statute (s. 440.13, F.S.) now applicable to thermograms. These additional tests would include: spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing. Charges for magnetic resonance imaging services would be limited to 75 percent of the Ingenix Customized Fee Analyzer. Hospitals and ambulatory surgical centers would not be subject to the fee schedule.

Pre-suit Notice — A claimant would be required to notify an insurer of an overdue claim, prior to filing an action against the insurer for an overdue claim. If the claim, along with applicable interest, is paid within 7 days, the claimant would be prohibited from bringing an action against the insurer for nonpayment or late payment of a claim.

Civil Action — A civil cause of action would be created for insurers against a person convicted of insurance fraud or patient brokering. Insurers prevailing under this section could recover compensatory, consequential, and punitive damages and attorney's fees.

Section 6. Amends s. 627.739, F.S., relating to deductibles. A provider would be prohibited from increasing charges to an insurer when the provider waives or fails to bill the co-payment or deductible. A provider would be required to notify the insurer at the time the claim is submitted that the co-payment or deductible was waived.

Section 7. Amends s. 817.234(8), F.S., relating to false or fraudulent insurance claims to specify that it is unlawful for any person to solicit or cause to be solicited by any means other than advertising directed to the general public. Charges for services rendered through solicitation would be considered an unlawful charge and would be unenforceable.

Section 8. Amends s. 324.021, F.S., to correct a cross-reference.

Section 9. Provides for a $100,000 appropriation and one-half of one full-time equivalent position to the Department of Health for the purposes of regulating medical clinics pursuant to s. 456.0375. F.S.

Section 10. Provides an effective date of upon becoming a law, except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Based on information provided by the Department of Health, the following revenues would be generated and expenditures used:

Department of Health	2001-02	2002-03
1,000 applicants X $150 per registration for first year	$150,000	$ 15,000
100 applicants X $150 registration for second year		
Medical Quality Assurance Trust Fund	$150,000	$ 15,000

2. Expenditures:

½ FTE Regulation Specialist	3,761
One-time printing and postage for mailout	35,000
One-time contractor expense for software Modification	1,500
OCO for ½ FTE	2,000
OPS 12 weeks X 40 hours X $10 per hour	4,800
TOTAL Non-recurring costs	**$ 47,061**

Salaries & Benefits	$ 17,263	$ 17,263

Although the law is effective October 1, 2001, the appropriation request is not lapsed, and requires a full 12 months funding for implementation preparation.

Contracted application processing and issuance of registrations	8,430	843
Expenses for ½FTE package	5,816	5,816
Contract with AHCA for Enforcement	15,000	50,000
TOTAL Recurring Costs	**$ 46,509**	**$ 73,922**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Any reduction in insurance fraud resulting from this legislation should reduce insurer loss experience and could result in premium savings for policyholders. Clinics subject to the registration requirement will incur costs associated with registration and employment of a medical director. These costs will be determined by rule of the Department of Health. Certain entities providing magnetic resonance imaging services will be limited to recovery of a maximum reimbursement rate. The impact on these entities depends on the degree to which the amount they charge for these services exceed the proposed maximum rate. Those entities providing certain other diagnostic tests specified in the bill will be subject to the fee schedule set for workers' compensation claims. Again, the extent of financial impact depends on the degree to which the amount they charge for these services exceed the proposed maximum rate.

Clinics that are required to register will be required to pay a registration fee. Clinics will also be required to employ a medical director. The Thirteenth, Fourteenth and Fifteenth Grand Jury Reports reflect an expectation that regulation of medical clinics will be a deterrent to insurance fraud. All clinics subject to regulation under this bill will be held to the same requirements.

D. FISCAL COMMENTS:

The Department of Health indicates that it does not have any data to suggest the volume of health care clinics that are operating in our state. Absent any data to reliably estimate the number of clinics that would be required to be registered, the fiscal impact estimate is based on an assumption that there would be 1,000 clinics that would register in the first year of implementation, FY 01-02. The fiscal analysis also assumes a 10 percent growth of 100 clinics in the second year.

The bill requires the registration to expire two years from the date of issuance, and to be renewed on a biennial basis. This will result in issuance of licenses on an ongoing daily basis, instead of the typical renewal schedule for health care professions, in which all licenses expire as an aggregate group on the same date every two years, instead of individually expiring on different days throughout the year.

There would be a one-time workload to develop the program, including specifications for data system modifications, distribution of information to licensees regarding the new registration requirements, and coordination with the AHCA regarding cross-checking of AHCA data about clinics that may already be licensed by AHCA and exempt from registration requirements. This

workload will require OPS funding for program development activities, and expense funding of $35,000 to cover expenses relating to printing and postage for mailout of information to approximately 50,000 licensed physicians regarding the new registration requirements. The Department maintains a database of application and licensing data on all regulated professions. Modifications to this computer system to add this new program would be accomplished by the department's Information Technology staff and would be accomplished within existing resources.

Based on the minimal registration requirements in the bill, the registration process will likewise be very streamlined. This registration program would be designed to utilize the department's current public/private model of application processing and issuance of licenses. The department's contract with a private business entity would be expanded to add this new program. The private contractor would receive the registration forms, process the forms, and issue the registration certificate. The current unit price for this application processing is $6.98 per application, and the unit price for issuing a certificate is $1.45, for a total of $8.43 per application and registration. Estimating 1,000 applications in FY 01-02, the contractor's charges would be 1,000 times $8.43 for a total of $8,430. The contractor would also likely charge an estimated $1,500 for one-time computer software program modifications to accommodate this new program.

During the first year, the department will utilize the department's website to publicize and provide information about registration requirements, and to provide registration applications for applicants to download and print, thus avoiding delays in requesting applications by mail. E-mail will also be utilized as extensively as possible for communication regarding registration questions. Given the minimal statutory registration requirements, applications that are submitted with complete information should not require the full 30 days provided by Chapter 120, F. S., for processing. It is anticipated that upon receipt of a complete application, a registration certificate should be returned to the applicant within a number of days.

The department is committed to maximizing the use of technology and "e-commerce" methodologies to enhance the efficiency of licensure programs. The department has recently successfully implemented internet based credit card transactions for renewal of nursing licenses. However, given the lack of information with which to reliably estimate the volume of clinics that will be required to register under this new program, the department is unable at this time to complete an analysis of the feasibility and cost-effectiveness of developing an internet based registration transaction system for this new registration program. In addition to information about the volume of clinics, other data system issues will require examination and analysis, including data security issues and data exchange with the AHCA regarding applicant licensure under other programs. It is expected that after the first year's experience, the department will have volume data and other information necessary to complete a feasibility analysis and proposal for an internet based credit-card application transaction system for initial applications as well as registration renewals.

The department will require ½ FTE Regulatory Specialist I (PG 15) to handle the ongoing operational responsibilities of this program, e.g., responding to inquiries, processing incomplete applications that are returned to the department by the contractor, and monitoring and reporting on issues related to the implementation and management of the program. First year funding for the ½ FTE is needed for a full 12 months, to ensure that the staff person is hired and trained prior to the October 1, 2001 implementation date. The department will also require initial OPS funding for program development and implementation activities, 12 weeks times 40 hours per week times $10 per hour.

The bill provides that registration fees shall be reasonably calculated to cover the costs of registration as well as compliance enforcement. The department through a contract with the ACHA handles compliance enforcement. The Agency conducts investigations of complaints that a

regulated licensee is not complying with licensure laws and rules. Enforcement of compliance is accomplished through these complaint investigations and subsequent penalties for violations. Historically, complaint data indicates that complaints are received regarding approximately three to five percent of licensees annually. Based on an assumption of 1,000 licensees, it is assumed that the AHCA will receive and investigate approximately 30 to 50 complaints annually. It is assumed that the AHCA will require $15,000 the first year, and $50,000 annually thereafter in appropriated spending authority to cover the costs of enforcement compliance activities.

This analysis does not include an assessment of the $5 "unlicensed activity" fee required under s. 456.065, F. S., per each licensee under health care professional practice acts administered by the department.

Based on the estimate of registration and enforcement costs, and on the variation in revenue in alternate years, the registration fee would need to be set at $150 to ensure sufficient cash to support enforcement activities in the alternate year of reduced revenue from fluctuating volume of registration renewal revenue.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

In 1999, the Fourth District Court of Appeal announced its decision in *Bradford v. State*, 740 So.2d 569 (Fla. 4th DCA 1999). In that case the court upheld the constitutionality of s. 817.234(8), F.S., prohibiting solicitation, but only when the solicitation was done with the intent of filing a fraudulent personal injury protection or motor vehicle claim. In *Hershkowitz v. State*, 744 So.2d 1268 (Fla. 3d DCA 1999), the Third District Court of Appeal, relying upon the opinion in *Bradford*, also held that s. 817.234(8), F.S., required intent to defraud. According to the Grand Jury, some court cases have been dismissed because of the *Bradford* decision.

Last year though, the Fourth District Court of Appeal ruled in another solicitation case, *Hansbrough v. State*, 757 So.2d 1282 (Fla. 4th DCA 2000), that it was receding from *Bradford* and that in fact fraudulent intent was never an element of s. 817.234(8), F.S. There is now a conflict between the districts. The Fourth District Court of Appeal has asked the Supreme Court of Florida to review the case and determine whether fraud is a necessary element of s. 817.234(8), F.S.

A further conflict between the District Courts of Appeal has developed. In *State v. Cronin*, 26 Fla. L. Weekly D149 (Fla. 1st DCA 2000), the First District Court of Appeal held that, while s. 817.234(8), F.S., does not require an intent to defraud, the statute is unconstitutional because it is "not narrowly tailored to only address the state's interest in preventing insurance fraud." Federal law requires, among other things, that regulations such as Florida's prohibition on solicitation contained in s. 817.234(8), F.S., must be narrowly tailored to the government's interest.[12] In *Cronin*, the First District Court of Appeal reasoned that the statute is so broad that it could be construed to prohibit general advertising by a chiropractor that even mentions victims of motor vehicle accidents. The Third and the Fourth District Court of Appeal have both upheld the constitutionality of s. 817.234(8), F.S. The conflict between the districts has been certified and is pending before the Florida Supreme Court.

The United States Supreme Court in *Shapero v. Kentucky Bar Association*, 486 U.S. 466, 108 S.Ct. 1916 (1989), found that a complete prohibition on direct mail advertising by lawyers targeted to a specific group of persons was unconstitutional because the state (the state bar association, in this instance) failed to "assert a substantial state interest" advanced by the regulation. However, the Court in *Shapero* clearly indicates that the state can regulate commercial speech to advance a substantial state interest. The First District Court of Appeal in the *Cronin* case relies on a case that follows *Shapero*.[13]

Until the Florida Supreme Court resolves the conflict between the districts and rules on whether s. 817.234(8), F.S., is sufficiently narrowly tailored to be constitutional, it is unclear if the statute is as narrowly tailored as necessary.

B. RULE-MAKING AUTHORITY:

The Department of Health would be given authority to implement rules regarding the registration procedure for clinics and the employment of a medical director.

C. OTHER COMMENTS:

The Department of Health provided the following comments:

The bill requires the registration of "clinics" at which "health care services" are provided and for which charges for reimbursement are tendered. The bill does not define "health care services". Questions may arise as to whether certain health facilities are included in this definition. For example, end-stage renal disease dialysis centers (ESRDs) are not licensed under Florida law but are certified under the federal Medicare program and subject to quality of care regulation by the AHCA. Nurses, physicians, and other licensed health care practitioners provide health care services at ESRDs. If an ESRD is not a 501(c)(3) non-profit organization and is not exclusively owned by physicians, then it may be considered to be a clinic for purposes of this bill. Another example would be a dental clinic, which by Florida law may only be owned by licensed dentists, or exempt as a 501(c)(3) non-profit organization, but may include a dental lab that is registered with the Department, in addition to the professional licensure of the practicing dentists. It may be helpful to add a definition of "health care services" to the bill.

One option for defining "health care services" is to clarify that a clinic is a facility at which health care services are provided, or are required by law to be provided, by health care practitioners licensed pursuant to Florida law. The bill could be amended to specifically refer to all, or selected,

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[12] See Board of Trustees of the *State Univ. of New York v. Fox*, 492 U.S. 469, 109 S.Ct. 3028 (1989) (modifying the four prong *Central Hudson* test for government regulation of commercial speech.)
[13] *Id.*

health care practitioners covered by Chapter 456, F. S., defined in s. 456.001(4), F. S. Consideration should be given to exclusion of certain regulated professions, e.g., athletic trainers, or medical physicists.

The bill exempts clinics that are otherwise licensed by the state pursuant to specified chapters of Florida Statutes. The list of specified statutes does not appear to include all health care facilities licensed by the state, e.g., Chapter 383, F. S., governs the licensure of birth centers by the AHCA, and Chapter 397, F. S., governs the licensure of substance abuse agencies by the Department of Children and Families.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 29, 2001, the Committee on Health Regulation adopted an amendment to strengthen the clinic registration provisions (Section 2) and to add the $100,000 appropriation for regulating medical clinics. The bill passed as a committee substitute.

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Meredith Woodrum Snowden	Stephen Hogge

AS REVISED BY THE COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Lucretia Shaw Collins	Lucretia Shaw Collins