SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Banking and Insurance Committee

BILL: CS/SB 2330

SPONSOR: Banking and Insurance Committee and Senator Alexander

SUBJECT: Insurance Fraud

DATE: April 6, 2005 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	**Fav/CS**
2.			HE	
3.			CJ	
4.			GA	
5.			JA	
6.				

I. Summary:

Committee Substitute for Senate Bill 2330 amends provisions of the Insurance Code pertaining to insurance fraud. The bill makes the following changes:

- Provides that it is a first degree felony if an employer knowingly fails to secure workers' compensation insurance for an employee when required by the workers' compensation law, and such employee subsequently suffers a work-related death;
- Provides that it is a second degree felony if an employer knowingly fails to secure workers' compensation insurance for an employee when required by the workers' compensation law, and such employee subsequently suffers a work-related injury requiring medical treatment;
- Extends the ban on waiving insurance deductibles or copayments to any service provider that bills insurers, not just medical providers;
- Enhances criminal penalties for "paper" or "phantom" motor vehicle accidents and provides for a two year minimum mandatory term of imprisonment;
- Provides that it is a third degree felony for a person to willfully violate an emergency rule or order promulgated by the Department of Financial Services;
- Requires health care clinics to post anti-fraud reward signs in conspicuous locations in facilities and allows fraud investigators access to such facilities to ensure clinic compliance;

- Provides criminal penalties for medical or clinic directors who refer patients to a clinic for specified services;

- Increases the penalty for transacting insurance without a license from a second-degree misdemeanor to a third-degree felony;

- Clarifies that consumers have a direct civil cause of action against individuals associated with unlicensed insurers;

- Allows alien surplus lines insurers to use irrevocable, unconditional, and evergreen letters of credit issued by a qualified U.S. financial institution to be used to fund the $5.4 million trust fund which serves to protect all policyholders;

- Clarifies what is meant by independent procurement of coverage (IPC) to state that IPC is coverage which is not solicited, marketed, negotiated, or sold in Florida; and,

- Provides that it is a third degree felony to solicit or receive a commission, bonus, kickback, or split-fee arrangement in return for acceptance of treatments from a health care provider or facility.

This bill substantially amends the following sections of the Florida Statutes: 400.9935, 440.105, 624.15, 624.155, 626.112, 626.901, 626.918, 626.938, 626.989, 817.234, 817.2361, 817.50, 817.505, and 843.08.

II. Present Situation:

Insurance Fraud Investigations by the Division of Insurance Fraud

Currently, the Division of Insurance Fraud (DIF) within the Department of Financial Services employs sworn law enforcement officers who investigate allegations of unauthorized insurance activities, fraudulent insurance acts, workers' compensation fraud, medical and health care fraud, unfair methods of insurance competition or unfair or deceptive insurance acts or practices.[1] These officers may make warrantless arrests upon probable cause for criminal violations established as a result of an investigation.[2] The general laws applicable to arrests by state law enforcement officers apply to Division investigators.

The DIF has 119 sworn officers located in five regions throughout the state. Under current law, insurance companies doing business in Florida and, other specified persons must report suspected fraud to the DIF. Persons and, entities providing those reports are protected from civil liability, provided the information is reported in good faith. The DIF also operates an anti-fraud reward program and provides up to $25,000 to persons for information leading to a conviction in insurance fraud cases.

[1] Section 626.989(2), F.S.
[2] Section 626.989(7), F.S.

According to DIF officials, it is estimated that insurance fraud costs the average Florida family as much as $1,500 a year in increased premiums and higher costs for goods and services. During 2002, the DIF presented 771 insurance fraud cases for prosecution, and won 458 convictions and more than $11.6 million in restitution.

Current law provisions are outlined below under the Effect of Proposed Changes.

III. Effect of Proposed Changes:

Section 1. Amends s. 400.9935, F.S., relating to responsibilities of a medical or clinic director and a health care clinic. Health care clinics are regulated under Part XIII of chapter 400, F.S., by the Agency for Health Care Administration (AHCA or agency). The agency licenses approximately 2,400 such clinics in the state and each clinic must appoint a medical or clinic director to supervise the various functions of the clinic under s. 400.9935, F.S. For example, a director must ensure that all practitioners maintain current licensure; that patient contracts or agreements are reviewed, that recordkeeping, office surgery and adverse incident reporting are in compliance; and that clinic billings are reviewed to ensure such billings are not fraudulent or unlawful.

The legislation would prohibit a medical or clinic director from referring patients to the clinic if the clinic performs magnetic resonance imaging, static radiographs, computed tomography, or position emission tomography[3] and defines the "referral of patients" to mean the referral of one or more patients of the medical or clinic director or a member of the medical or clinic director's group practice to the clinic for such services. The bill provides that it is a third degree felony for a medical or clinic director to violate this provision.

Current law provides for an Anti-Fraud Reward Program to be established within the DFS which is funded from the Insurance Regulatory Trust Fund.[4] Under the program the DFS may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the DIF arising from specified violations. Only a single reward amount may be paid out for claims arising from the same transaction.

The bill requires that every health care clinic post a "reward" sign in a conspicuous location within the clinic which is clearly visible to all patients. The sign must state that the DFS may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud (DIF) arising from the following violations:

- s. 440.105, F.S., relating to prohibited activities under the workers' compensation law;
- s. 624.15, F.S., relating to willful violations of the Insurance Code;

[3] *Magnetic resonance imaging* (MRI) is a noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves; *computer tomography* is radiography in which a three-dimensional image of a body structure is constructed by computer from a series of plane cross-sectional images made along an axis (called also computed axial tomography, computerized axial tomography, computerized tomography*); position emission tomography* is a highly specialized imaging technique that uses short-lived radioactive substances to produce three-dimensional colored images of those substances functioning within the body; these images are called PET scans and the technique is termed PET scanning.

[4] Section 626.9892, F.S.

- s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts under the Insurance Code;
- s. 626.989, F.S., relating to resisting an arrest or otherwise interfering with DIF investigators; or
- s. 817.234, F.S., relating to false and fraudulent insurance claims.

Present law requires the Agency for Health Care Administration (AHCA or agency) to make inspections of health care clinics as part of the initial license application and renewal application procedures.[5] The agency may also make unannounced inspections of licensed clinics as necessary to determine compliance with the Health Care Clinic Act under Part XIII of chapter 400, F.S.

The bill provides that authorized employees of DIF (sworn law enforcement investigators) would have the authority to make unannounced inspections of licensed clinics as necessary to determine whether the clinic is in compliance with the signage provisions and requires clinics to allow full and complete access to such employees. This inspection provision is in addition to the authority currently granted AHCA employees as noted above.

Section 2. Amends s. 440.105, F.S., relating to prohibited acts under the workers' compensation law. The workers' compensation system provides indemnity and medical benefits to injured employees. In order for an employee to be entitled to workers' compensation benefits, the law requires that the injury "arise out of" and be in the course and scope of the employment.[6]

The bill strikes a conflicting criminal penalty that makes a violation of a stop-work order that is issued by the Department of Financial Services (DFS) a 1st degree misdemeanor because such violation is presently a third degree felony.

The bill provides that it is a second degree felony if an employer knowingly fails to secure workers' compensation insurance for an employee when required by the workers' compensation law, and such employee subsequently suffers a work-related injury requiring medical treatment. It would be a first degree felony if an employer knowingly fails to secure workers' compensation insurance for an employee when required by the workers' compensation law, and such employee subsequently suffers a work-related death.

Presently, employers who fail to secure payment of compensation are subject to felony penalties which are based upon the degree of monetary value of the violation.[7] According to officials with DFS, stronger criminal penalties are needed in this area and they point to an incident which occurred in July 2004, when two workers were killed in a construction accident on a Hobe Sound work site and it was later discovered that the employer had failed to provide workers' compensation coverage for the employees. The employer was subsequently charged with a third-degree felony.

[5] Section 400.9915, F.S.
[6] Section 440.9935, F.S.
[7] Under s. 440.105(4)(f), F.S., it is a third degree felony if the monetary value of the violation is less than $20,000; a second degree felony if the value is $20,000 or more, but less than $100,000; and, a first degree felony if the monetary value is $100,000 or more.

Section 3. Amends s. 624.15, F.S., pertaining to general penalties under the Insurance Code. The bill adds "or rule of the department or office" to the language in the statute that states that "each willful violation of this Code…" is a misdemeanor of the 2nd degree (unless otherwise specifically provided by statute). Under current law, the DFS, and the Financial Services Commission for the OIR, may issue rules on subjects within their respective jurisdictions. The effect of this provision would be to make it a criminal penalty for insurance agents and insurers (or other persons or entities involved in the business of insurance and licensed by either agency) to willfully violate any DFS or OIR rule.[8]
The bill would also make each willful violation of a DFS *emergency rule or order* a third degree felony. This provision would be in addition to current penalties pertaining to the denial, suspension, or revocation of a certificate of authority, license or permit. Each instance of such violation is a separate offense.

The DFS may issue emergency rules after a natural disaster (hurricane) or other types of emergencies depending on the nature of the insurance issue.[9] During the 2004 hurricane season, the DFS issued approximately 12 emergency rules pertaining to public adjusters, mediation, and insurance agents. Under the bill, an adjuster or agent who willfully violates a department rule is subject to being criminally charged with a third degree felony.

Section 4. Amends s. 624.155, F.S., relating to civil remedies against insurers. Under current law, any party may bring a civil action against an unauthorized insurer if the party has been damaged by a violation of s. 624.401, F.S.[10] According to representatives with OIR, the language in the law only allows a suit to be brought against an "entity" (unauthorized insurer) itself, not the "individual" responsible for such damage. This bill would clarify the law to allow a party to bring a civil action against "any person" acting as an insurer without a certificate of authority if such party is damaged by that person. Therefore, if the unauthorized insurer is dissolved, the individuals responsible for operating the insurer could be subject to civil law suits.

Section 5. Amends s. 626.112, F.S., relating to licensing requirements for agents, adjusters and others, to enhance the criminal penalty for such agents, adjusters, and other licensees who transact insurance without a license. Specifically, the bill provides that any person who transacts insurance or engages in insurance activities in Florida without a license commits a third degree felony. Under current law (s. 624.15, F.S.) it is a second degree misdemeanor for a person who transacts insurance and willfully (intentionally) does not obtain a license. Under the bill, an unlicensed agent or adjuster who transacts insurance would be subject to a criminal felony penalty regardless of the willfulness of such person.

Section 6. Amends s. 626.901, F.S., which applies to prohibitions against representing or aiding an unauthorized insurer, to clarify what is meant by independently procured coverage (IPC). Currently, subsection (4) of s. 626.901, F.S., exempts *independently procured coverage* (IPC)

[8] The Florida Supreme Court in *Avatar v. State*, 723 So.2d 199 (Fla. 1998) held that a statute declaring unlawful (1st degree misdemeanor) any violation of a permitting rule promulgated by the Dept. of Environmental Protection was constitutionally a valid delegation of legislative authority to the administrative agency.
[9] Under s. 120.54, F.S., agencies are authorized to issue emergency rules if necessary to protect the public health, safety or welfare.
[10] Section 624.401, F.S., requires persons transacting insurance to obtain a certificate of authority (COA) and mandates criminal penalties for persons who do not obtain a COA.

from being included within the definition of unauthorized insurance. This bill clarifies that IPC coverage is *not coverage which is solicited, marketed, negotiated, or sold* in Florida. This clarification is necessary, according to OIR officials, because some unauthorized insurers have asserted the defense that they are soliciting or selling IPC and therefore are not in violation of the unauthorized entities provisions.

Section 7. Amends s. 626.918, F.S., relating to eligible surplus lines insurers. The bill allows alien surplus lines insurers (out of country) to use irrevocable, unconditional, and evergreen letters of credit issued by a qualified U.S. financial institution to be used to fund the $5.4 million trust fund which serves to protect all policyholders. A "qualified U.S. financial institution" is defined to mean to an institution that is organized or is licensed under the laws of the United States, is regulated and examined by the U.S. or state authorities, and has been determined to meet specified financial standards.

Section 8. Amends s. 626.938, F.S., pertaining to reporting and taxing of independently procured coverage (IPC). The law currently allows persons in Florida to independently procure insurance from foreign (out of state) or alien (out of country) insurers that do not hold a Florida certificate of authority (COA) and to pay all necessary taxes and fees. The bill clarifies independently procured coverage to provide that every insured who "resides" in Florida and procures insurance "from another state or country" with an unauthorized insurer "legitimately licensed in that other jurisdiction," or any self-insurer who "resides" in this state and so procures insurance, must within 30 days file a report with the Florida Surplus Lines Service Office. As noted under section 6, above, this clarification is necessary because some unauthorized insurers have asserted the defense that they are soliciting or selling IPC and therefore are not in violation of the unauthorized entities provisions of the Insurance Code.

The bill also provides that IPC may not be secured for workers' compensation coverage.

Section 9. Amends s. 626.989, F.S., relating to the powers and duties of the Division of Insurance Fraud (DIF) within the DFS. Under current law, certain persons are required to report suspected fraudulent insurance activity to DIF, and that requirement triggers civil immunity for such persons.[11] These persons include any insurer, agent or person licensed under the Insurance Code, a medical review committee, or a professional practitioner licensed or regulated by the Department of Business and Professional Regulation. The bill extends civil immunity protection to a self-insured entity contracting or associated with the National Insurance Crime Bureau (NICB) and authorizes the DIF to adopt rules that set forth the manner in which suspected fraudulent activity shall be reported.

Officials with DIF claim that frequently the NICB and entities associated with it share suspected fraud information with the DIF and, it is important to provide these entities with civil immunity protections.

Section 10. Amends s. 817.234, F.S., pertaining to the false and fraudulent insurance claims law. Under current law, any physician and, other healthcare provider (except hospitals) who waives

[11] In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or other tort (s. 626.989(4)(c)), F.S.

deductibles or copayments as a general business practice commits insurance fraud. The bill would extend the application of the statute to any "service" provider. The proposal also deletes the term 'patient' and inserts the term 'insured' pertaining to the waiver of deductibles or copayments with the provider.

Present law provides that it is a second degree felony (with a 2 year minimum mandatory term of imprisonment) to plan or organize an intentional motor vehicle crash for the purpose of making a tort claim. The bill creates a new penalty provision by making it a second degree felony (with a 2 year minimum mandatory term of imprisonment) to plan or organize a "scheme to create documentation of a motor vehicle crash that did not occur" for purposes of a tort claim. According to representatives with DFS, adding the crime of a "paper accident" would greatly deter motor vehicle insurance fraud.

Section 11. Amends s. 817.2361, F.S., relating to false or fraudulent motor vehicle insurance. Current law makes it a third degree felony to create, market, or present a false or fraudulent insurance card. The bill expands the applicability of the statute to provide that any person who presents false or fraudulent "proof of" motor vehicle insurance commits a third degree felony.

Section 12. Amends s. 817.50, F.S., pertaining to fraudulently obtaining goods and services from a health care provider. Under current law, if a person provides a health care provider with a false name or address or assigns to any provider the proceeds of any health maintenance contract or insurance contract, then knowing that such contract is invalid, such action shall be prima facie evidence of the intent to defraud such provider. The bill adds language to protect investigators who are engaged in undercover police investigations. It provides that the law does not apply to investigative actions taken by law enforcement officers for law enforcement purposes in the course of their official duties. This provision will help DIF investigators according to the DFS.

Section 13. Amends s. 817.505, F.S., relating to patient brokering. Presently, it is a third degree felony for a person or health care provider or facility to pay or bribe in cash or in kind to induce the referral of patients from or to a health care provider or health care facility. The bill would add a provision stating that it is a third degree felony to solicit or receive any commission, bonus, rebate, kickback, or bribe in cash or in kind or engage in a split-fee arrangement in any form whatsoever in return for the acceptance or acknowledgment of treatment from a health care provider or facility. The bill amends the definition of a health care provider or health care facility to add that such provider or facility be licensed, certified, or registered; or lawfully exempt from licensure, certification, or registration with the Agency for Health Care Administration. It is not clear what the effect of the bill would be to broaden the definition of health care provider or facility to include "lawfully" unlicensed, uncertified or unregistered providers or facilities.

Section 14. Amends s. 843.08, F.S., pertaining to falsely personating an officer. Currently, it is a third degree felony to falsely assume or pretend to be a specified law enforcement officer. The bill adds an officer of the Department of Financial Services.

Section 15. Creates a new, undesignated provision which states that if any provision of this act is held invalid, the invalidity does not effect other provisions or applications of the act.

Section 16. Provides that the act shall take effect on July 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health care clinics would be responsible for placing anti-fraud reward signs in conspicuous locations within their clinics and must allow complete access to their premises to law enforcement personnel within the DIF to make inspections to determine compliance with the signage requirement. Medical or clinic directors would be subject to 3rd degree felony provisions if such directors referred patients to the clinic for specified services.

Persons would be subject to increased penalties, including criminal prosecution, for various acts specified by the bill.

C. Government Sector Impact:

Representatives with the DFS stated that the responsibilities set forth within the bill will be carried out within the existing resources of the agency.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.