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: Criminal Justice Committee

BILL:	CS/CS/SB 2330
SPONSOR:	Criminal Justice Committee, Banking and Insurance Committee and Senator Alexander
SUBJECT:	Offenses Involving Insurance
DATE:	April 27, 2005 REVISED:

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

I. Summary:

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

- 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, other than a hospital, that bills insurers, not just medical providers who bill patients;
- 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 a rule or an emergency rule or order of the Department of Financial Services (DFS), the Office of Insurance Regulation, or the Financial Services Commission (penalties for a willful violation of an emergency rule or order will not apply to licensees or affiliated parties of licensees);
- 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 directors or clinic directors who refer patients of the medical director or clinic director to their 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 clean, irrevocable, unconditional, and evergreen letters of credit issued by a qualified U.S. financial institution to fund the $5.4 million trust fund that serves to protect all policyholders;
- Clarifies what is meant by independent procurement of coverage to state that independent procurement of coverage is coverage which is not solicited, marketed, or sold in Florida;
- 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;
- Provides that it is a first degree misdemeanor to knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statements to any person as evidence of identity for the purpose of obtaining employment (by including this offense in s. 448.09, F.S., relating to prohibited employment of unauthorized aliens), and that hiring unauthorized aliens is also a first degree misdemeanor.
- Requires the Division of Insurance Fraud of the Department of Financial Services to deposit revenues received from criminal proceedings or forfeiture proceedings into the Insurance Regulatory Trust Fund.

This CS amends ss. 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, 843.08, and 932.7055, F.S., and creates s. 626.9893.

II. Present Situation:

Insurance Fraud Investigations by the Division of Insurance Fraud

The Division of Insurance Fraud (DIF) within DFS 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 DIF investigators.

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.

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, DIF presented 771 insurance fraud cases for prosecution, and won 458 convictions and more than $11.6 million in restitution.

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

The law provides for an Anti-Fraud Reward Program to be established within DFS which is funded from the Insurance Regulatory Trust Fund.[3] Under the program, 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 DIF arising from specified violations. Only a single reward amount may be paid out for claims arising from the same transaction.

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.[4] 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.

Certain persons are required to report suspected fraudulent insurance activity to DIF, and that requirement triggers civil immunity for such persons.[5] 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.

DFS may issue emergency rules after a natural disaster (hurricane) or other types of emergencies depending on the nature of the insurance issue.[6] During the 2004 hurricane season, the DFS issued approximately 12 emergency rules pertaining to public adjusters, mediation, and insurance agents. Under the CS, an adjuster or agent who willfully violates a department rule is subject to being criminally charged with a third-degree felony.

DFS, and the Financial Services Commission for the Office of Insurance Regulation (OIR), may issue rules on subjects within their respective jurisdictions.

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.[7] 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.

Under current law, any physician or other health care provider (except hospitals) who waives deductibles or copayments as a general business practice commits insurance fraud.

[3] Section 626.9892, F.S.
[4] 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.
[5] 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.).
[6] Under s. 120.54, F.S., agencies are authorized to issue emergency rules if necessary to protect the public health, safety, or welfare.
[7] 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.

Present law provides that it is a second-degree felony (with a two-year minimum mandatory term of imprisonment) to plan or organize an intentional motor vehicle crash for the purpose of making a tort claim.

Worker's Compensation

Any person or entity defined as an employer by ch. 440, F.S., is required to provide workers' compensation coverage to its employees. 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.[8]

Health Care Clinics

Health care clinics are regulated under part XIII of ch. 400, F.S., by the Agency for Health Care Administration (AHCA). AHCA licenses approximately 2,400 such clinics in the state, and each clinic must appoint a medical director 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.

AHCA must inspect health care clinics as part of the initial license application and renewal application procedures.[9] AHCA may also make unannounced inspections of licensed clinics as necessary to determine compliance with the Health Care Clinic Act under part XIII of ch. 400, F.S.

III. Effect of Proposed Changes:

Section 1. Amends s. 400.9935, F.S., to prohibit a medical director or clinic director from referring patients to the clinic if the clinic performs magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography[10] and defines the "referral of patients" to mean the referral of one or more patients of the medical director or clinic director or a member of the medical director or clinic director's group practice to the clinic for such services. The CS provides that it is a third degree felony for a medical director or clinic director to violate this provision, punishable by a fine of up to $5,000 and a term of imprisonment of up to five years, with enhanced penalties for repeated offenses.

[8] Section 440.9935, F.S.
[9] Section 400.9915, F.S.
[10] *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; *computed 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*); positron 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.

The CS requires every health care clinic to 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 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 general penalties for willful violations of the Insurance Code;
- 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.

The CS 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 CS strikes a criminal penalty in s. 440.105(2)(a), F.S., that makes a violation of a stop-work order that is issued by DFS a first-degree misdemeanor. Unless it is deleted, this provision is in conflict with the penalty provided in s. 440.105(4)(b), F.S., which makes such a violation a third-degree felony.

The CS deletes a provision in s. 440.105(3)(b), F.S., which provides that it is unlawful for any employer to knowingly participate in the creation of the employment relationship in which the employee has used any false, fraudulent, or misleading oral or written statement as evidence of identity. This offense is a first degree misdemeanor.

The CS deletes a provision in s. 440.105(4(b). F.S., which provides that it is unlawful to knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of identity for the purpose of obtaining employment or filing or supporting a claim for workers' compensation benefits. This offense is a third degree felony, second degree felony, or first degree felony, depending on the monetary value of the violation.

Section 3. Amends s. 448.09, F.S., relating to unauthorized aliens and prohibitions on employment, to provide that it is unlawful to knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statements to any person as evidence of identity for the purpose of obtaining employment. The CS deletes a current civil penalty and second degree misdemeanor penalty applicable to this section and provides that a violation of this new offense or the current offense in the section relating to hiring an unauthorized alien is a first degree misdemeanor.

The CS 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.

Under the CS, 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.

Section 4. Amends s. 624.15, F.S., which establishes general penalties under the Insurance Code. The CS would make a willful violation of a rule of the department, office, or commission, as well as a willful violation of the Insurance Code, a misdemeanor of the second-degree (unless otherwise specifically provided by statute). The CS would also make each willful violation of a *emergency rule or order* of the department, office, or commission a third-degree felony, punishable by a term of imprisonment not to exceed five years or a fine of not more than $5,000. 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. However, this, provision does not apply to licensees or affiliated parties of licensees.

Section 5. Amends s. 624.155, F.S., relating to civil remedies against insurers. This CS 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 6. 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 CS provides that any person who transacts insurance or engages in insurance activities in Florida without a license commits a third-degree felony regardless of the willfulness of such person.

Section 7. 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. Currently, subsection (4) of s. 626.901, F.S., exempts *independently procured coverage* from being included within the definition of unauthorized insurance. This CS clarifies that "independently procured coverage" coverage is *not coverage, which is solicited, marketed, 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 independently procured coverage and therefore are not in violation of the unauthorized entities provisions.

Section 8. Amends s. 626.918, F.S., relating to eligible surplus lines insurers. The CS allows alien surplus lines insurers (out of country) to use clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed 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 U.S. or any state in the U.S., is regulated and examined by the U.S. or state authorities, and has been determined to meet specified financial standards.

Section 9. Amends s. 626.938, F.S., pertaining to reporting and taxing of independently procured coverages. 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 and to pay all necessary taxes and fees. The CS clarifies that every insured who in this state procures insurance "from another state or country" with an unauthorized insurer "legitimately licensed in that jurisdiction," or any self insurer who in this state so procures insurance, must within 30 days file a report with the Florida Surplus Lines Service Office. This clarification is necessary because some unauthorized insurers have asserted the defense that they are soliciting or selling independently procured coverage and therefore are not in violation of the provisions of the Insurance Code pertaining to unauthorized entities. The CS also provides that any insurance on a risk in an unauthorized insurer legitimately licensed in another state or country procured through solicitations, negotiations, or an application occurring or made outside this state shall be deemed to be insurance procured. The CS also provides that independently procured coverage may not be secured for workers' compensation coverage.

Section 10. Amends s. 626.989, F.S., relating to the powers and duties of DIF. The CS extends civil immunity protection to a self-insured entity contracting or associated with the National Insurance Crime Bureau (NICB) who reports suspected fraudulent insurance activity to DIF. The CS authorizes DIF to adopt rules that set forth the manner in which suspected fraudulent activity must be reported. Officials with DIF claim that frequently the NICB and entities associated with it share suspected fraud information with DIF and, it is important to provide these entities with civil immunity protections.

Section 11. Amends s. 817.234, F.S., pertaining to the false and fraudulent insurance claims law. The CS provides that any service provider (except a hospital) who waives deductibles or copayments as a general business practice commits insurance fraud. The proposal also deletes the term "patient" and inserts the term "insured" to designate the person for whom, or entity for which, a service provider would agree to waive deductibles or copayments.

The CS creates a new penalty making it a second-degree felony (with a two-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 12. 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 CS deletes the word "card" and 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 13. 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, knowing that such contract is invalid, such action shall be prima facie evidence of the intent to defraud such provider. The CS 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 DFS.

Section 14. 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 CS would make it 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 CS amends the definition of a health care provider or health care facility to add that such provider or facility be required to be licensed, certified, or registered; or lawfully exempt from licensure, certification, or registration with AHCA. It is not clear how broad the effect of this change might be if the definition of health care provider or facility includes "lawfully" unlicensed, uncertified or unregistered providers or facilities.

Section 15. 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 CS extends this penalty to the impersonation of an officer of DFS.

Section 16. Creates s. 626.9893, F.S., to provide that the Division of Insurance Fraud of the Department of Financial Services may deposit revenues received as a result of criminal proceedings or forfeiture proceedings, other than revenues deposited into the Department of Financial Services' Federal Equitable Sharing Trust Fund under s. 17.43, F.S., into the Insurance Regulatory Trust Fund. Moneys deposited pursuant to this provision shall be separately accounted for and shall be used solely for the division to carry out its duties and responsibilities.

Moneys deposited into the Insurance Regulatory Trust Fund pursuant to this section shall be appropriated by the Legislature, pursuant to the provisions of ch. 216, F.S., for the sole purpose of enabling the division to carry out its duties and responsibilities.

Notwithstanding the provisions of s. 216.301, F.S., and pursuant to s. 216.351, F.S., any balance of moneys deposited into the Insurance Regulatory Trust Fund pursuant to this section remaining at the end of any fiscal year shall remain in the trust fund at the end of that year and shall be available for carrying out the duties and responsibilities of the Division of Insurance Fraud.

Section 17. Amends s. 932.7055, F.S., relating to disposition of liens and forfeited property, to provide that if the seizing agency is the Division of Insurance Fraud of the Department of Financial Services, the proceeds accrued pursuant to the provisions of the Florida Contraband Forfeiture Act shall be deposited into the Insurance Regulatory Trust Fund as provided in s. 626.9893, F.S., or into the Department of Financial Services' Federal Equitable Sharing Trust Fund as provided in s. 17.43, F.S., as applicable.

Section 18. Provides for severability of the provisions of the CS. If any provision of the CS is held invalid, the invalidity does not affect other provisions or applications of the CS.

Section 19. Provides an effective date of July 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health care clinics will 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 from DIF to make inspections to determine compliance with the signage requirement. Medical directors or clinic directors would be subject to third-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 CS.

C. Government Sector Impact:

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

The Criminal Justice Estimating Conference states that the penalty provisions of this legislation have an indeterminate, but likely insignificant, prison bed impact.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.