HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 967 CS Offenses Involving Insurance
SPONSOR(S): Cannon
TIED BILLS: HB 1443 **IDEN./SIM. BILLS:** SB 2330

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	15 Y, 0 N, w/CS	Callaway	Cooper
2) State Administration Appropriations Committee		Rayman	Belcher
3) Commerce Council			
4)			
5)			

SUMMARY ANALYSIS

The bill relates primarily to insurance fraud in all types of insurance. The bill:

- requires that every health care clinic licensed under Chapter 400 post a sign that indicates individuals may receive rewards for furnishing to the Division of Insurance Fraud (DIF) reports and information about committing crimes investigated by DIF that lead to arrest and conviction;
- allows DIF fraud investigators access to health care clinics to ensure clinic compliance;
- creates new law relating to penalties for an employer's failure to secure workers' compensation;
- provides any willful violation of an administrative rule of DFS would be a second degree misdemeanor;
- makes each willful violation of an emergency rule or emergency order of DFS a third degree felony with each willful violation considered a separate offense;
- clarifies 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;
- 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;
- increases the penalty for transacting insurance without a license from a second-degree misdemeanor to a third-degree felony;
- extends civil immunity protection for reporting suspected insurance fraud to DIF 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;
- extends the ban on waiving insurance deductibles or co-payments to any service provider that bills insurers, not just medical providers;
- enhances criminal penalties for "paper" or "phantom" motor vehicle accidents;
- 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;
- provides an exception to the statute pertaining to fraudulently obtaining goods and services from a health care provider for investigative actions taken by law enforcement officers for law enforcement purposes;
- includes falsely personating an officer of DFS in the list of officers it is unlawful to personate; and
- revises criteria unauthorized insurers must meet to become surplus lines insurers.

The fiscal impact on the private sector includes increased penalties, including criminal prosecution, for various acts specified in the bill. **The Criminal Justice Estimating Conference has not yet evaluated the prison bed impact of this bill on the Department of Corrections. Without the Estimating Conference it is not possible to determine the fiscal impact of this bill on state and local government.**

The effective date of the bill is July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government: The bill requires the Agency for Health Care Administration (AHCA) to make sure each health care clinic has the required sign posted relating to rewards for information regarding insurance fraud. Enforcement of the sign posting requirement will be done by the Department of Financial Services (DFS).

Safeguard Individual Liberty & Promote Personal Responsibility: The bill creates new penalties for an employer's failure to secure workers' compensation insurance. It creates new penalties for violations of a department rule, emergency rule or emergency order. It creates a new penalty for insurance licensees transacting insurance or engaging in insurance activities without a license. It creates a new penalty for fabrication of "paper" motor vehicle accidents. It adds new circumstances constituting unlawful patient brokering.

B. EFFECT OF PROPOSED CHANGES:

General Background

Insurance Fraud Investigations by the Division of Insurance Fraud: Currently, the Division of Insurance Fraud (DIF) within the Department of Financial Services (DFS) employs sworn law enforcement officers who investigate allegations of unauthorized insurance activities, fraudulent insurance acts, 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 arrested over 900 people allegedly connected to more than $25 million in personal injury fraud in the past five years. More than 70 people face or are serving the minimum prison sentence.[3]

Health Care Clinics

Health care clinics are defined as entities at which health care services are provided to individuals and which tender charges for reimbursement for such services.[4]

Health care clinics are primarily licensed by the Agency for Health Care Administration (AHCA).[5] The term "medical director" means a physician, employed by or under contract with a clinic, who maintains an unencumbered physician license in accordance with chs. 458 (physicians), 459 (osteopathic physicians), 460 (chiropractors), or 461 (podiatrists), F.S.[6]

Under current law, there is no requirement in the health care licensure statute (ch. 400) for health care clinics to post signs relating to rewards for insurance fraud. Current law provides for an Anti-Fraud Reward Program to be established within the DFS which is funded from the Insurance Regulatory Trust Fund.[7] 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

[1] s. 626.989(2), F.S. (2004).
[2] s. 626.989(7), F.S. (2004).
[3] Baird Helgeson, "Bill Targets Insurance Shenanigans," The Tampa Tribune, 5 April 2005.
[4] s. 400.9905(4), F.S. (2004).
[5] See s. 400.9905(4), F.S. for a listing of entities that are not required to be licensed by AHCA.
[6] s. 400.9905(5), F.S. (2004).
[7] s. 626.9892, F.S. (2004).

specified violations. Only a single reward amount may be paid out for claims arising from the same transaction.

Additionally, current law requires the AHCA to make inspections of health care clinics as part of the initial license application and renewal application procedures.[8] AHCA 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 requires that every medical clinic licensed under Chapter 400 post a sign that indicates that individuals may receive rewards for furnishing to the Division of Insurance Fraud (DIF) reports and information about committing crimes investigated by DIF that lead to arrest and conviction. The sign must be posted in a conspicuous location visible to all patients The crimes the posting would disclose are:

- 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;
- 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.

Enforcement of the posting requirement will be done by the DFS. Sworn law enforcement investigators of DIF would have the authority to make unannounced inspections of licensed clinics to ensure that such requirement is being met. The bill requires the clinics to allow "full and complete access to the premises" to DIF employees to determine whether the clinic is complying with the posting requirements.

The clinic director or medical director will be responsible for posting the sign relating to insurance fraud. The clinic would be required to post the sign in a conspicuous location visible to all patients.

Workers' Compensation

The Division of Workers' Compensation (DWC) within DFS and the DIF within DFS work closely together to carry out their statutory duties. The DWC enforces administrative compliance with the workers' compensation law, pursuant to s. 440.107, F.S. The DIF enforces the criminal provisions of the workers' compensation law, pursuant to s. 440.105, F.S. The divisions have developed and implemented a referral program to facilitate the referral of cases between the divisions so that each division can determine if an investigation will be initiated from the referral. According to the DWC, referrals are made to each division within 24 hours of a suspected violation of the law, and are considered a priority to be acted upon immediately.

During fiscal year 2003-2004, the DWC referred 113 employers to the DIF for possible criminal investigation. During the same time period, the DIF submitted 19 referrals to the DWC for administrative investigations.

The DWC also has a referral program with the Department of Business and Professional Regulation (DBPR). If an employer is suspected of failing to secure workers' compensation coverage during a DBPR investigation of the employer, then DBPR refers the employer to the DWC. If, during an investigation by the DWC, an employer is suspected of working without a required state license, the DWC refers the employer to DBPR for further investigation.

The DWC also works closely with many local building and permitting agencies to identify employers who may not have workers' compensation, employers who may be unlicensed, and/or employers who may be in violation of local ordinances. It also works with the Department of Revenue and the Division of Corporations within the Department of State to help identify employers operating without the required workers' compensation insurance.

[8] s. 400.9915, F.S. (2004).

According to the DFS, DFS took administrative and/or criminal action against more than 1,800 Florida employers last fiscal year for evading more than $25 million in workers' compensation premiums. Actions taken by DFS resulted in more than 13,000 workers receiving workers' compensation coverage.

Under current law, an employer who operates without workers' compensation insurance commits insurance fraud. The punishment is based on the monetary value of the violation. If the monetary value is less than $20,000, current law provides a third degree felony is committed. If the monetary value is $20,000 through $99,999, current law provides a second degree felony is committed. If the monetary value is $100,000 or more, current law provides a first degree felony is committed.

According to DFS representatives, stronger criminal penalties are needed for employers who do not obtain workers' compensation insurance when they are required by law to obtain such insurance. To support the need for stronger criminal penalties in this area, DFS representatives 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.

The bill creates penalties for an employer's failure to secure workers' compensation. The penalties provided previously based on the monetary value of the violation would not apply in cases where an employee is injured on the job but whose employer knowingly did not provide workers' compensation insurance in violation of Chapter 440. In these cases, if an employee's injury requires hospitalization, the employer commits a second degree felony. If an employee's injury results in death, the employer commits a first degree felony.

Violations of Administrative Rules, Emergency Rules, or Emergency Orders

The Florida Insurance Code (Code) is contained in chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.[9] The Code contains numerous penalty provisions in it which are specific to a particular violation. However, the Code also contains general penalty provisions that apply for violations of the Code when no other penalty is provided in the Code or in other applicable laws. Section 624.15, F.S. is a general penalty provision in the Code. It makes any willful violation of the Code a second degree misdemeanor.

The bill amends the general penalty provision in s. 624.15, F.S. to include willful violations of an administrative rule of DFS. Therefore, any willful violation of an administrative rule of DFS would be a second degree misdemeanor. Each instance of the willful violation will be considered a separate offense. According to DFS, this provision would allow DIF investigators to enforce violations of DFS rules (by misdemeanor arrest) the same way they may currently enforce violations of the Insurance Code.

The provision criminalizing violations of DFS rules is limited to rules adopted by DFS and not to the rules adopted by the Financial Services Commission for the Office of Insurance Regulation (OIR). This provision would be in addition to current penalties pertaining to the denial, suspension, or revocation of a certificate of authority, license or permit.

Under current law, the DFS may issue emergency rules after a natural disaster (hurricane) or other types of emergencies depending on the nature of the insurance issue.[10] During the 2004 hurricane season, the DFS issued approximately 12 emergency rules pertaining to public adjusters, mediation, and insurance agents.

[9] s. 624.01, F.S. (2004).

[10] Under s. 120.54, F.S., agencies are authorized to issue emergency rules if necessary to protect the public health, safety or welfare.

The bill adds a provision to the general penalty provision in s. 624.15, F.S. The added provision makes each willful violation of an emergency rule or emergency order of DFS a third degree felony with each willful violation considered a separate offense. There is no criminal penalty in current law for willful violations of emergency rules or emergency orders

Unauthorized Insurers

Under current law, insurance companies transacting insurance in Florida are required to obtain a certificate of authority (COA) issued by the OIR. An unauthorized insurer is an entity that does not have a COA to transact insurance business in Florida. The law provides specific penalties for entities, or their representatives, that engage in such activities.

The law provides four exceptions to the definition of unauthorized insurance for the following:

- Activities authorized or accomplished on behalf of OIR under the Unauthorized Insurers Process law, ss. 626.904-626.912, F.S.;
- Surplus lines insurance when written pursuant to the Surplus Lines Law, ss. 626.913-626.937, F.S.;
- Transactions for which a COA is not required of an insurer under s. 624.402, F.S.; and
- Independently procured coverage written pursuant to s. 626.938, F.S.

According to staff of OIR, the typical unauthorized insurance company is often a criminal enterprise disguised as an insurance company. [11] Their operations are usually national and sometimes international in scope, and they may claim to be licensed in a foreign country. These companies write policies and collect premiums, but do not pay claims. Instead, such enterprises typically take the premiums and other assets of the company and move them offshore where they are difficult to find and even more difficult to retrieve, and ultimately prosecute. These unauthorized insurers defraud thousands of insurance consumers in Florida.

The Office of Insurance Regulation reports that over the past few years (as of September, 2003)[12] more than 4,423 Floridians have reported being left with $17.8 million in unpaid claims from unauthorized insurers. Cases of fraud involving unauthorized entities operating in Florida have involved health care claims as well as property damage, workers' compensation, watercraft damage, and liability claims.

When OIR receives complaints alleging unauthorized activity, the complaint is turned over to the Market Investigations Unit to investigate potential administrative violations, while the same complaint is referred to both the Division of Agent and Agency Services within DFS if the case involves a licensed insurance agent, and to the Division of Insurance Fraud within the DFS for determination as to criminal violations.

In 2003, the Legislature passed legislation giving consumers a direct civil cause of action against unauthorized insurers by whom they had been damaged.[13] According to DFS, the legislation passed in 2003 could be interpreted to mean that a civil suit can only be brought against the unauthorized insurer entity itself, not the persons behind the unauthorized insurer or responsible for it. 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.

Independently Procured Coverage: Independently procured coverage (IPC) is insurance coverage that an insured in Florida, typically a business, obtains by directly contacting an unauthorized foreign or

[11] The DFS licenses insurance agents and investigates criminal activities of unauthorized insurers and agents representing unauthorized insurers. The OIR issues certificates of authority (COA) to insurers. Both the OIR and DFS exercise powers relating to unauthorized entities within their respective jurisdictions.
[12] This is the most recent information available according to OIR representatives.
[13] Ch. 2003-148, L.O.F.

alien[14] insurer, or self insurer.[15] The insured must file specific information about the policy with the Florida Surplus Lines Service Office (Office) and must pay 5 percent of the gross amount of the premium and a 0.3 percent service fee to the Office.

Currently, subsection (4) of s. 626.901, F.S., exempts *independently procured coverage* (IPC) from being included within the definition of unauthorized insurance. The 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.

The bill amends s. 626.938, F.S., pertaining to reporting and taxing of 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. 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.

Licensing and Appointment of Insurance Agents, Customer Service Representatives, Adjusters, Insurance Agencies, Service Representatives, & Managing General Agents

The bill provides a penalty for insurance agents, adjusters, and other licensees who transact insurance or engage in insurance activities without a license. The penalty provided for such activity is 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.

Division of Insurance Fraud

Under current law, certain persons are required to report suspected fraudulent insurance activity to DIF, and that requirement triggers civil immunity for such persons.[16] 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.

False and Fraudulent Insurance Claims

[14] Insurers are divided into three categories under the Insurance Code: *domestic insurers* are formed under the laws of Florida; *foreign insurers* are formed under the laws of any state, district, or territory or commonwealth of the United States, other than Florida; and *alien insurers* are defined as insurers other than domestic or foreign insurers. Foreign and alien insurers must meet certain capital, surplus, and operational requirements.

[15] s. 626.938, F.S. (2004).

[16] 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. (2004)).

Under current law, any physician and other healthcare provider (except hospitals) who waives deductibles or co-payments 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.

Current law provides that it is a second degree felony (with a 2 year minimum 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 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 deter motor vehicle insurance fraud. DFS officials estimate that bogus automobile insurance claims add $240 to every automobile insurance policy each year and increase costs for goods and services.[17]

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.

Under current law, giving a false or fictitious name to a health care provider, giving a false or fictitious address to a health care provider, or assigning the proceeds of any health maintenance contract or insurance contract to a health care provider knowing the contract is invalid or void is prima facie evidence the person giving false information has intent to defraud the health care provider.[18] According to staff at DFS, during the course of an insurance fraud investigation by DFS, a DFS investigator may give a false name or address or false information relating to a health insurance policy to a health care provider DFS is investigating. This information is given to a health care provider in order for DFS to obtain information about the medical treatment given by and billing practices of the health care provider.

There are no exceptions for activities of law enforcement officers giving false or fictitious information for law enforcement purposes under current law. The bill amends current law to provide such an exception. The bill's provision in this regard will protect investigators who are engaged in undercover police investigations.

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.

Under current law, for the purposes of patient brokering, a health care provider or health care facility is defined, in part, as "any person or entity licensed, certified, or registered." The bill amends the definition of a health care provider or health care facility to include providers "required to be licensed, certified, or registered; or lawfully exempt from being required to be licensed, certified, or registered" with the Agency for Health Care Administration.

Falsely Personating Officer

Falsely personating certain officers specified in s. 843.08, F.S. subjects the personator to criminal penalties. The officers specified in s. 843.08, F.S. are:

[17] Baird Helgeson, "Bill Targets Insurance Shenanigans," The Tampa Tribune, 5 April 2005; Personal communication from DFS on file with the Insurance Committee.
[18] s. 817.50,(2), F.S. (2004).

- Sheriff,
- Officer of the Florida Highway Patrol,
- Officer of the fish and Wildlife Conservation Commission,
- Office of the Department of Environmental Protection,
- Officer of the Department of Transportation,
- Officer of the Department of Corrections,
- Correctional Probation Officer,
- Deputy Sheriff,
- State Attorney,
- Assistant State Attorney,
- Statewide Prosecutor,
- Assistant Statewide Prosecutor,
- State Attorney Investigator,
- Coroner,
- Police Officer,
- Lottery Special Agent,
- Lottery Investigator,
- Beverage Enforcement Agent,
- Watchman,
- Any member of the Parole Commission,
- Any administrative aide of the Parole Commission,
- Any supervisor of the Parole Commission, or
- Any personnel or representative of the Florida Department of Law Enforcement.

The bill adds "officer of the Department of Financial Services" to the list of officers. Thus, falsely assuming or pretending to be an officer of DFS will be a third degree felony, unless the officer is personated during the commission of a felony in which case personating an officer of DFS is a second degree felony. However, if the commission of a felony results in death or personal injury of another, then the penalty for personating a DFS officer becomes a first degree felony.

Surplus Lines Insurers

Surplus lines insurance refers to a high risk category for which there is no market available through standard insurance carriers. Typical categories of this nature are homeowners' insurance in hurricane-prone regions, commercial aircraft, and some sea vessels. Additionally, there are some types of specialized risks that general lines policies cannot cover. For example, special events, such as concerts or major sports exhibitions, may not be eligible for coverage by licensed general lines insurers.

Under current law, surplus lines insurance is governed by ss. 626.913 through 626.938, F.S. When insurance coverage is not available among licensed general lines insurers, the insurers may seek coverage in the surplus lines market. The law requires the general lines agent to make a diligent effort to procure the desired coverage from authorized agents. A diligent effort is defined by law to mean seeking and being denied coverage from at least three authorized agents. Surplus lines insurers also are regulated by the state, but to a lesser degree than general lines insurers.

The Florida Surplus Lines Service Office (the office) is created by s. 626.921, F.S., as a nonprofit association overseen by a Board of Governors comprised of nine members. Seven of the nine board members must be affiliated with the surplus lines industry. The office is directed to oversee the surplus lines industry in Florida and to provide protection of the general public with respect to the placement of surplus lines policies. The office is authorized by law to collect fees from licensed surplus lines agents, based upon the premiums collected, in order to pay the administrative and other costs associated with the office.

Under current law, in general surplus lines agents may not place any coverage with any unauthorized insurer which is not an eligible surplus lines insurer.[19] An unauthorized insurer cannot become a surplus lines insurer unless the statutory conditions specified in s. 626.918(2), F.S., are met. One of the conditions is the insurer must have and maintain surplus of at least $15 million.[20] Another condition is the insurer must have and maintain a trust fund in the U.S. of at least $5.4 million. The purpose of the trust fund is to provide additional protection to the insurer's U.S. policyholders. The statute further provides what type of funds can be used to satisfy the surplus and trust fund requirements.

In addition to the types of funds which can be used by alien surplus lines insurers to satisfy the surplus and trust fund requirements, the bill adds the 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. The bill also defines the term "qualified U.S. financial institution" to mean U.S. banks that are members of the Federal Reserve system.

C. SECTION DIRECTORY:

Section 1: Amends s. 400.9935, F.S., requiring posting of a sign in health care clinics relating to insurance fraud; allowing DFS employees to access health care clinics to enforce compliance with the posting requirement.

Section 2: Amends s. 440.105, F.S., creating new penalties for employers who fail to secure workers' compensation coverage and whose employees are injured in a work related accident.

Section 3: Amends s. 624.15, F.S., providing a penalty for willful violations of an administrative rule of DFS, of an emergency rule of DFS, or of an emergency order of DFS.

Section 4: Amends s. 624.155, F.S., providing a civil remedy for any person damaged as a result of a person acting as an insurer without a certificate of authority to transact insurance in Florida.

Section 5: Amends s. 626.112, F.S., providing a penalty for persons transacting insurance or insurance activities without a license.

Section 6: Amends s. 626.901, F.S., relating to the prohibition to aid or represent an unauthorized insurer.

Section 7: Amends s. 626.918, F. S., pertaining to surplus lines insurers.

Section 8: Amends s. 626.938, F.S., pertaining to reporting and taxing of independently procured coverage.

Section 9: Amends s. 626.989, F.S., extends civil immunity protection to a self-insured entity contracting or associated with the National Insurance Crime Bureau (NICB); authorizing the DIF to adopt rules that set forth the manner in which suspected fraudulent activity shall be reported.

Section 10: Amends s. 817.234, F.S., pertaining to the false and fraudulent insurance claims law.

Section 11: Amends s. 817.2361, F.S., 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., providing an exception to the statute pertaining to fraudulently obtaining goods and services from a health care provider for investigative actions taken by law enforcement officers for law enforcement purposes.

Section 13: Amends s. 817.505, F.S., relating to patient brokering.

[19] s. 626.918 (1), F.S. (2004).
[20] S. 626.918(2)(d)1., F.S. (2004).

Section 14: Amends s. 843.08, F.S., including falsely personating an officer of DFS in the list of officers it is unlawful to personate.

Section 15: Provides for severability to protect the validity of provisions or applications of the act if any provision of the act is held invalid.

Section 16: Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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.

Persons would be subject to increased penalties, including criminal prosecution, for various acts specified by the bill. Criminal fines ordered by a Court pursuant to Section 775.083, F.S., states that such criminal fines must be deposited in the trust fund for the clerk of the circuit court for that particular county, such fund being created by Section 142.01, F.S.

D. FISCAL COMMENTS:

Regarding the posting of a sign relating to insurance fraud in health care clinics, AHCA does not believe this requirement will have a fiscal impact on it.[21]

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

The Criminal Justice Estimating Conference has not yet evaluated the prison bed impact of this bill on the Department of Corrections. Without the Estimating Conference it is not possible to determine the fiscal impact of this bill on state and local government.

[21] Agency for Health Care Administration 2005 Bill Analysis & Economic Impact Statement on file with the Insurance Committee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to take an action requiring the expenditure of funds, does not reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not reduce the percentage of state tax shared with counties or municipalities.

2. Other:

The criminal provisions related to violations of DFS rules, emergency rules, and/or emergency orders may, in part, refer to administrative rules to define the offense. A criminal offense cannot be defined by reference to administrative code. *See B.H. v. State*, 645 So.2d 987 (Fla. 1994). However, in *Avatar Development Corp. and Tanel v. State*, 723 So.2d 199 (Fla. 1998), the Supreme Court held a statute constitutional that allowed the Department of Environmental Protection to enforce a criminal penalty for violation of a department rule. In deciding the *Tanel* case, the Court reviewed the *B.H.* case, but found it inapposite to the facts in *Tanel*.

B. RULE-MAKING AUTHORITY:

The DIF is authorized to adopt rules relating to the manner in which suspected fraudulent activity is reported to DIF in a standardized referral form.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Regarding the posting of a sign relating to insurance fraud in health care clinics, the Agency for Health Care Administration indicated its Health Care Clinic Unit would add a check for this sign as one of the criteria to be reviewed during on-site surveys of clinics conducted by AHCA field staff.[22]

Regarding the bill's provisions relating to workers' compensation, the bill does not detail who is considered the "employer" if the employer is punished according to the statutory provisions for felony convictions. For example, the bill does not specify who is considered the "employer" for imprisonment purposes, if the employer is convicted of a felony for not having workers' compensation insurance and an employee is injured on the job which results in hospitalization or death. DFS has indicated the "employer" who will be prosecuted is the person responsible for procuring workers' compensation insurance.[23] This person will vary from employer to employer.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 6, 2005, the Insurance Committee adopted two amendments and reported the bill favorably with a committee substitute. The amendments changed the original text of the bill as follows:

- amends the title of the bill from "an act relating to insurance" to "an act relating to offenses involving insurance" to narrow the scope of the bill and to conform the title to the Senate companion bill, SB 2330.
- adds a section to the bill revising criteria unauthorized insurers must meet to become surplus lines insurers. The added section 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 required $5.4 million trust fund which serves to protect all policyholders. The amendment also defines the term "qualified U.S. financial institution" to mean U.S. banks that are members of the Federal Reserve system.

The staff analysis was updated to reflect the amendments adopted in the Insurance Committee.

[22] Agency for Health Care Administration 2005 Bill Analysis & Economic Impact Statement on file with the Insurance Committee.
[23] Telephone conversation with a representative from DFS on April 5, 2005.