The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1306
INTRODUCER:	Senator Bradley
SUBJECT:	Insurance Fraud
DATE:	March 30, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			CJ	
3.			AP	

I. Summary:

SB 1306 amends provisions relating to health care clinics who seek reimbursement under the Florida Motor Vehicle No-Fault Law. The bill requires an entity exempt from clinic licensure requirements to obtain a certificate of exemption from the Agency for Health Care Administration if the clinic treats 10 or more patients or seeks reimbursement pursuant to the Florida Motor Vehicle No-Fault Law in order to receive reimbursement. The bill requires clinics owned by physicians, dentists, and chiropractic physicians to obtain a certificate of exemption. The bill provides that unlawful claims for reimbursement under the Florida No Fault Law are considered theft, regardless of whether payments are made.

In 2012, the Department of Financial Services established a direct-support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The direct support organization has engaged in limited organizational activity during its existence. The bill repeals the statute authorizing the direct support organization.

The bill requires insurers to file annual updates with the division relating to their special investigative units (SIUs) and annually provide anti-fraud training to its underwriting, claims adjusting, and SIU personnel.

II. Present Situation:

Licensure Requirements for PIP

Section 627.736(5)(h), F.S., requires all entities meeting the definition of a "clinic" in s. 400.9905(4), F.S., to be licensed by the Agency for Health Care Administration (AHCA) as a health care clinic in order to receive reimbursement pursuant to the Florida Motor Vehicle No-

Fault Law,[1] unless the entity is wholly owned by a doctor, dentist, chiropractor, or hospital, or is a hospital, ambulatory surgical center, or clinical facility affiliated with a medical school. Under s. 400.9935(6), F.S., these exempted entities may voluntarily apply to the AHCA for a certificate of exemption from licensure or may self-exempt and operate a health care clinic. According to the Department of Financial Services (DFS), the AHCA has no record of the self-exempted clinics and this lack of records facilitates straw ownership and other clinic insurance fraud schemes.[2]

Unlicensed Clinics and Unlawful Charges

Section 408.812, F.S., prohibits an unlicensed clinic from offering or advertising services that require licensure by the AHCA and prohibits a person or entity from owning, operating, or maintaining an unlicensed provider. Violations of 408.812, F.S., are punished as third degree felony[3] for a first offense and a second degree felony[4] for a second or subsequent offense.[5] Section 408.812(3), F.S., requires any health care provider who is aware of the operation of an unlicensed clinic to report that facility to the AHCA. Failure to report a clinic that the provider knows or has reasonable cause to suspect is unlicensed shall be reported to the provider's licensing board.[6]

Section 400.9935(3), F.S., provides that the charges and reimbursement claims made by a health care clinic that is required to be licensed under ss. 400.990-995, F.S., but is not licensed or is operating in violation of the referenced statutes, are unlawful, noncompensable, and unenforceable. According to the DFS, s. 400.9935(3), F.S., has routinely been applied in the civil context to permit insurance companies and third parties to deny paying, or to recover payments for, such unlawful charges. However, the DFS believes that prosecutors have been reluctant to file criminal theft charges because the theft statute does not specifically name such unlawful charges as theft.[7]

Special Investigative Units

Section 626.9891, F.S., requires each insurer admitted to do business in this state, if the insurer received $10 million or more in direct premiums during the previous calendar year, to establish a unit, commonly referred to as a Special Investigations Unit (SIU), to investigate possible insurance claim fraud or to contract with others to investigate such fraud. The insurer must file a detailed description of the SIU with, or provide a copy of the contract to the DFS Division of Insurance Fraud ("division").[8] If the insurer received less than $10 million in direct premiums during the previous calendar year, the insurer must submit an anti-fraud plan to the division which describes its procedures to detect, investigate, and report suspected insurance fraud, its

[1] *See* ss. 627.730–627.7405, F.S.
[2] *See* Department of Financial Services, *Agency Bill Analysis SB 1306*, March 13, 2015 (on file with the Banking and Insurance Committee).
[3] A third degree felony is punishable by up to 5 years imprisonment. *See* s. 775.082, F.S.
[4] A second degree felony is punishable by up to 15 years imprisonment. *See* s. 775.082, F.S.
[5] *See* s. 400.993, F.S.
[6] *See* s. 400.993(3), F.S.
[7] *See* Department of Financial Services, *Agency Bill Analysis SB 1306*, March 13, 2015 (on file with the Banking and Insurance Committee).
[8] *See* s. 626.9891(1), F.S.

plan for anti-fraud training for its personnel, and its organizational arrangement of anti-fraud personnel.[9].

Currently only workers' compensation insurers are required to report the following to the Department on or before August 1 of each year:

- The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.
- The number of fraud referrals submitted for the prior year.
- A description of the organization of its SIU, if applicable.
- The rationale for the level of staffing and resources being provided for the SIU.
- The in-service anti-fraud education and training provided to personnel.
- A description of a public awareness program focused on insurance fraud and methods by which the public can prevent it.

Under law, if an insurer fails to comply with the requirements for SIUs or anti-fraud plans or with the workers' compensation reporting requirement, statute authorizes the DFS, OIR, or Financial Services Commission (FSC) to impose certain administrative fines, as warranted by the circumstances.

Automotive Insurance Fraud Strike Force

Section 626.9895, F.S., authorizes the division to establish a direct-support organization, known as the "Automobile Insurance Fraud Strike Force" (DSO). The DSO's sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The DSO is authorized to raise funds, conduct programs and activities, hold, invest, and administer assets in its name, and make grants and expenditures to state attorneys' offices, the statewide prosecutor, the AHCA, and the Department of Health to be used exclusively to prosecute, investigate, or prevent motor vehicle insurance fraud.

The Strike Force filed its incorporation with the Department of State on April 25, 2012. The Strike Force has engaged in limited organizational activity during its existence. The DFS reports that the Strike Force has not: taken in any donations, paid any grants, established a bank account or made any transfers into the Insurance Regulatory Trust Fund.

III. Effect of Proposed Changes:

Licensure Requirements for PIP

Section 4 of the bill requires an entity exempt from clinic licensure requirements to obtain a certificate of exemption from the AHCA if it treats 10 or more patients or seeks reimbursement pursuant to the Florida Motor Vehicle No-Fault Law in order to receive reimbursement under the Florida No Fault Law. This bill would require clinics owned by physicians, dentists, and chiropractic physicians to obtain a certificate of exemption in order for the clinics to receive reimbursement under the Florida No Fault Law. Section 1 of the bill makes conforming changes to s. 400.9905, F.S.

[9] *See* s. 626.9891(2), F.S.

Section 3 of the bill requires a separate certificate of exemption for each clinic location and creates a third degree felony for filing a false or misleading application for a certificate of exemption.

Unlicensed Clinic Activity and Unlawful Charges

Section 2 of the bill repeals s. 400.993, F.S. Those provisions are moved to s. 400.9935, F.S.

Section 3 of the bill consolidates existing criminal offenses provisions into s. 400.9935, F.S. The bill creates a new third degree felony offense applicable to any person who knowingly fails to report a change in information contained in the most recent health care clinic license application or a change regarding the required insurance or bonds. The bill provides that a person who knowingly makes an unlawful charge commits theft in violation of s. 812.014, F.S.

Special Investigative Units

Section 5 of the bill amends s. 626.9891, F.S., to require insurers to file annual updates with the division relating to their SIUs and annually provide anti-fraud training to its underwriting, claims adjusting, and SIU personal.

The bill requires every admitted insurer to establish and maintain or contract for the establishment and maintenance of, an SIU that is responsible for the detection, investigation, and reporting of suspected insurance fraud. The bill requires each SIU to:

- Be separate from the insurer's underwriting, claims adjusting, and other units.
- Establish written procedures for the detection, investigation, and reporting of suspected insurance fraud.
- Be composed of personnel who have documented knowledge of the insurer's procedures for underwriting, issuing, and renewing policies and handling insurance claims, who have documented knowledge of insurance fraud law, and have documented knowledge of the insurer's written procedures for detecting and reporting insurance fraud.

The bill requires all insurers to file a written description of the insurer's procedures for the detection, investigation, and reporting of suspected insurance fraud and requires insurers to annually file updated procedures and information relating to anti-fraud training. New insurers must comply within 3 months of receipt of certificates of authority.

The bill requires insurers to report statistical information to the division on an annual basis. The report must include:

- The number of policies in effect.
- The amount of direct premiums written for policies.
- The number of applications received for policies.
- The number of claims filed that are referred or investigated by insurers.
- The number of reports of suspected insurance fraud submitted to the division and to other entities.
- :The number of cases involving suspected insurance fraud which were civilly litigated.
- The dollar amounts of the insurer's exposure for claims in which there was suspected insurance fraud.

- The dollar amounts paid by the insurer for claims in which there was suspected insurance fraud.
- The dollar amounts recovered by the insurer through restitution resulting from criminally prosecuted insurance fraud cases.
- The dollar amounts recovered by the insurer through judgments or settlements resulting from civilly litigated insurance fraud cases.
- The dollar amounts paid by the insurer for judgments or settlements resulting from civilly litigated insurance fraud cases.
- The rationale for the level of staffing and resources being provided for the SIU.
- A description of a public awareness program provided by the insurer.

The bill requires the DFS to review required filings for compliance with the law and empowers the DFS to impose administrative fines for noncompliance. The OIR is required to conduct market conduct examinations to determine compliance.

The bill provides that an insurer claiming that documents or other information submitted to the DFS or the OIR are trade secrets may file an action with the circuit court to determine whether the documents are trade secrets.

Sections 6 and 7 of the bill impose the insurance fraud compliance and reporting requirements on Citizens Property Insurance Corporation and on admitted health maintenance organizations.

Miscellaneous

Section 5 of the bill provides that additional costs incurred in compliance with the bill must be included as administrative expense for ratemaking purposes.

Sections 8 and 9 of this bill repeal the motor vehicle fraud direct support organization.

Section 10 of the bill amends the Criminal Punishment Code to reflect new crimes created by the bill. The bill will rank the crimes created or amended on the Offense Severity Ranking Chart. Third degree felonies that would rank as a Level 1 by default are ranked by the bill as Level 3. The second degree felony referenced in the bill is ranked as a Level 6.

Section 11 of the bill provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurers will have increased costs complying with the anti-fraud requirements and reporting requirements of this bill. The amount is indeterminate.

C. Government Sector Impact:

The DFS reports there could be an indeterminate increase in expenditures for rulemaking and administrative litigation related to this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.9905, 400.9935, 627.736, 626.9891, 627.351, 641.3915, 626.9894, and 921.0022.

This bill repeals the following sections of the Florida Statutes: 400.993 and 626.9895.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.