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HOUSE OF REPRESENTATIVES
COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: HB 1743

RELATING TO: Insurance Fraud

SPONSOR(S): Representatives Wiles and Cosgrove

COMPANION BILL(S):

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

(1) INSURANCE
(2) JUDICIARY
(3) GOVERNMENTAL RULES AND REGULATIONS
(4) GENERAL GOVERNMENT APPROPRIATIONS
(5)

I. SUMMARY:

The concept of insurance fraud is not addressed in just one section of Florida Statutes. Rather, insurance fraud is addressed in a variety of different statutory sections relating to violations of the insurance code. For example, Florida has enacted laws relating to "fraudulent insurance acts" (s. 626,989(1), F.S.), "false and fraudulent insurance claims" (s. 817.234, F.S.), workers' compensation fraud (s. 440.105(4), F.S.) and "unfair insurance trade practices" (Part X, Chapter 626, F.S.). In addition, there are statutes prohibiting theft, forgery, and bribery and statutes relating to unlawful financial transactions, unlawful business solicitation, and misrepresentations.

In December of 1998, the Fourteenth Statewide Grand Jury released three reports relating to insurance fraud -- (1) Report on Insurance Insolvency Fraud, (2) Report on Health Care Claims Fraud, and (3) Report on Fraud in the Non-Standard Insurance Industry. In these reports, the Grand Jury identified various fraudulent activities occurring in these areas and made recommendations for legislative change.

This bill would make a variety of changes to Florida law relating to insurance fraud and would adopt several of the Grand Jury's recommendations. Some of the bill's changes include:

- Criminal penalties for insurance fraud would be increased;
- Statutes of limitations for prosecuting insurance fraud would be extended;
- An Anti-Fraud Reward Program would be established;
- HMOs would be required to file anti-fraud plans;
- Specific provisions would be created relating to fraud by persons engaged in the business of insurance; and
- The Attorney General, state attorneys, and the Department of Insurance would be authorized to bring civil suits for monetary damages.

The bill would appropriate $250,000 from the Insurance Commissioner's Regulatory Trust Fund to implement the Anti-Fraud Reward Program.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Insurance Fraud

According to *Black's Law Dictionary*, "fraud" is an "intentional perversion of the truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or surrender a legal right." The concept of insurance fraud is not specifically addressed in one section of Florida Statutes. Rather, insurance fraud is addressed in a variety of different sections relating to violations of the insurance code.

For example, Florida has enacted laws relating to "fraudulent insurance acts" (s. 626,989(1), F.S.), "false and fraudulent insurance claims" (s. 817.234, F.S.), and "unfair insurance trade practices" (Part X, Chapter 626, F.S.). In addition, there are statutes prohibiting theft, forgery, and bribery and statutes relating to unlawful financial transactions, unlawful business solicitation, and misrepresentations.

Division of Insurance Fraud

The Division of Insurance Fraud (Division) is a law enforcement agency within the Department of Insurance. The Division has the statutory duty to investigate "fraudulent insurance acts" (s. 626.989(1), F.S.), unfair insurance trade practices (s. 626.9541, F.S.), "false and fraudulent insurance claims" (s. 817.234, F.S.), workers' compensation fraud (s. 440.105(4), F.S.), and acts punishable under s. 624.15, F.S. (the general penalty that makes any violation of the Insurance Code at least a second degree misdemeanor).[1]

Insurer anti-fraud units

Since 1996, each insurer has been required under s. 626.9891, F.,S., to establish an anti-fraud unit to investigate potential fraudulent claims, contract with a vendor to provide the services of an anti-fraud unit, or, in the case of an insurer that writes less than $10 million in premiums in a year, establish and file with the Department an anti-fraud plan. The requirements do not apply to a health maintenance organization (HMO), because an HMO is not included within the definition of an "insurer." Section 626.9891, F.S., does not give the Department the authority to approve or disapprove an insurer's anti-fraud unit, contract, or plan.

Criminal penalties and statute of limitations

The criminal penalty for false and fraudulent insurance claims and applications (s. 817.234, F.S.) is a third-degree felony, punishable by up to 5 years in prison and a fine of up to $5,000. By virtue of the general penalty provision, s. 624.15, F.S., second degree misdemeanor penalties (up to 60 days in county jail and a fine of up to $500) apply to any violation of the Insurance Code for which no other criminal penalty is specified.

Under s. 775.15, F.S., a prosecution for a third-degree felony must be commenced within 3 years after it was committed, and a prosecution for a misdemeanor must be commenced within 1 year after it was committed. If the limitation period has expired and fraud is a material element of the crime, the prosecution may be commenced within 1 year after the fraud is discovered, but this exception cannot be used more than 3 years after the end of the original limitation period.

Workers' compensation fraud is punishable based on a sliding scale which depends on the amount involved in fraudulent activity. See s. 440.105(4)(f), F.S. (1998 Supplement). Furthermore, prosecutions of workers' compensation fraud must be commenced within 5 years after the fraud is discovered. See s. 775.15(2)(h), F.S. (1998 Supplement).

Rewards

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

There is no statutory authorization for the Department of Insurance to provide cash rewards to persons who provide information leading to insurance fraud convictions. Various other state agencies have statutory authorization for reward programs.[2]

Statewide Grand Jury Reports on Insurance Fraud

The Fourteenth Statewide Grand Jury was impaneled on August 19, 1997, and was seated in the Second Judicial Circuit: Leon County. The panel was drawn from around the state. The Grand Jury met on 13 occasions to investigate allegations of multi-circuit, organized criminal activity. The Grand Jury's original term expired after twelve months, but was extended to February 19, 1999.

The Grand Jury primarily investigated cases involving insurance fraud, with an emphasis on workers' compensation premium fraud, health care claim fraud, insolvency fraud and consumer fraud. It issued 13 indictments charging 78 defendants and 5 businesses with a total of 508 crimes. The indictments allege the following criminal offenses: racketeering; conspiracy to racketeer; grand theft; insurance fraud; organized fraud; insurance solicitation, workers' compensation fraud; failure to secure workers' compensation; securities fraud; sale of unregistered securities; sale of securities by unlicensed dealer; unauthorized transaction of insurance; false evidence of compliance and false entry in books of corporation.

In December of 1998, the Grand Jury released its final three reports on insurance fraud -- (1) Insurance Insolvency Fraud, (2) Health Care Claims Fraud, and (3) Non-Standard Insurance Industry Fraud. These reports, cited as Supreme Court Case No. 90,703, are summarized below.

Insurance Insolvency Fraud

The Grand Jury report considered an insurance company insolvent when its financial condition falls below certain minimum state requirements. The Grand Jury defined insurance insolvency fraud as criminal activity by company insiders which causes an insurance company to become insolvent; or fraudulent activity designed to hide a company's true financial condition from state regulators.

According to the Grand Jury, insurance company insolvencies not only impact the companies' policyholders, they impact everyone. Since 1993, a total of 21 insurance companies doing business in the state of Florida have become insolvent. Of these insolvencies, the Grand Jury suspected criminal activity in 14 of the cases. According to the Grand Jury, insolvencies of insurance companies doing business in Florida where crime has either caused or contributed to their condition have cost insurance guaranty associations approximately $435,945,000 over the past five years -- which costs are ultimately passed on to policy holders.

Based on the work involved in investigating and prosecuting these cases, the Grand Jury believed the current statutes addressing insurance fraud do not specifically address insolvency fraud as forcefully or as specifically as they should. The Grand Jury noted that the Legislature has always relied upon general criminal statutes to combat insolvency fraud. The Grand Jury reported that these statutes were not designed with insolvency fraud in mind and do not carry sufficiently stiff penalties.

Health Care Claims Fraud

In this report, the Grand jury focused on fraudulent practices in the area of health care claims submitted to private insurance companies and self-insurance programs.

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[2] See, e.g., ss. 106.24, 212.0515, 372.073, 372.911, 373.614, 590.16, 790.164, and 944.402, F.S. The value of authorized rewards varies; for example, the Department of Corrections is authorized to pay a reward of up to $100 for a person who assists in the apprehension of an escapee, while the Department of Law Enforcement is authorized to pay a reward of up to $5,000 for information leading to the arrest and conviction of a person who makes a false bomb threat. Not all rewards are stated as flat amounts; for example, the Department of Revenue is authorized to pay a reward of up to 10 percent of the unpaid vending machine taxes recovered as a result of the informant's information.

Citing the Department of Insurance, the Grand Jury reported that fraudulent health insurance claims amount to $4.8 billion each year. Based on this figure, the Grand Jury stated "every insurance consumer family in the state pays over $1,066 in additional health insurance premiums annually."

The Grand Jury found that a variety of health care fraud scams are presently being perpetrated in Florida. According to the Grand Jury, these scams include:

- submitting medical bills from actual clinics for services that were never performed or unnecessary;
- submitting false medical bills from fictitious clinics either by using information from real patients and physicians or fictitious physicians;
- recruiting and paying insured persons to go to storefront clinics for routine physicals;
- forcing patients to undergo tests and procedures they do not need; and
- using runners to solicit accident victims to visit chiropractors.

Fraud in the Non-Standard Insurance Industry

The third report released by the Grand Jury in December of 1998 dealt with insurance fraud in the non-standard insurance industry. According to the Grand Jury report, "non-standard" insurance agencies provide automobile insurance and other related products to consumers not able to secure insurance from standard insurance companies because of their driving history, age, and costs.

The Grand Jury learned through the course of its investigation that, in addition to selling insurance, "many of these agencies offer optional non-insurance related products (i.e. towing clubs, legal plans, and life insurance) to their customers as an added means of profit for the agency. Unfortunately [the Grand Jury has] learned that deception, misrepresentation and other fraudulent means are often used in order to insure these ancillary products are sold."

The Grand Jury's investigation revealed several different schemes used by non-standard agencies to cause consumers to purchase ancillary products that they may not want or need. One scheme involves agencies including the cost of the ancillary product in the base quote for insurance. For example, assume the base cost of insurance is $100 and the cost of the ancillary product is $50. Under this scheme, the agency would quote the base cost for insurance as $150 and tell the consumer that this price includes the additional product. However, the agency would not tell the consumer that the product is optional. Another related scheme involved agencies advising consumers that if optional products were refused, the cost of insurance would be higher or that the consumer could not be insured.

Yet another scheme discovered by the Grand Jury involved agencies selling ancillary products to consumers who did not even know that they had purchased an ancillary product. The Grand Jury found that some agencies would provide a series of forms for the consumer to sign without explaining the product's benefits. Through what the Grand Jury referred to as a "sign here, sign here, sign here" approach, the consumer would unknowingly purchase ancillary products.

The Grand Jury recognized that s. 626.9541(1)(z), F.S., relating to the practice of "sliding," encompasses many of the activities discovered by the Grand Jury. This section, which carries a penalty of a second degree misdemeanor, currently provides:

> Sliding is the act or practice of:
>
> 1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of motor vehicle insurance when such coverage or product is not required;
>
> 2. Representing to the applicant that a specific ancillary coverage or product is included in the motor vehicle policy applied for without an additional charge when such charge is required; or
>
> 3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the motor vehicle insurance coverage applied for, without the informed consent of the applicant.

However, the Grand Jury believed that this section does not cover all the fraudulent activity it discovered.

Grand Jury Recommendations

Based on its investigations, the Grand Jury concluded that Florida was a "fraud friendly" state. In order to make Florida less "fraud friendly," the Grand Jury made many recommendations for statutory change.[3] These recommendations include:

- Increasing criminal penalties for insurance fraud;
- Increasing criminal penalties for patient brokering;
- Increasing statutes of limitations for insurance fraud prosecutions;
- Creating incentive programs for the reporting of insurance fraud;
- Requiring insurers to demonstrate they have allocated sufficient resources and implemented policies and procedures to identify fraud as a condition of receiving rate increases;
- Requiring all medical facilities, including non-physician owned clinics, to be licensed by the state;
- Requiring insurance companies and HMOs to verify the existence of medical facilities prior to paying bills;
- Requiring HMOs to implement SIUs like other insurers; and
- Establishing specialized prohibitions against fraudulent activities by persons engaged in the business of insurance.

B. EFFECT OF PROPOSED CHANGES:

This bill would implement a variety of the recommendations of the Grand Jury. Specifically:

- Criminal penalties for insurance fraud would be increased using a sliding scale based on the value of the property involved in the fraudulent activity;
- The statute of limitations for prosecuting insurance fraud would be extended from 3 years to 5 years;
- The Department of Insurance would have the authority to suspend the license of an insurer for failing to follow insurance fraud reporting requirements;
- HMOs would be included in the definition of "insurer" for purposes of the definition of "fraudulent insurance act;"
- All HMOs and insurers, including those writing more than $10 million which have established SIUs, would be required to file detailed anti-fraud plans with the Department;
- Specific provisions relating to insurance fraud by persons engaged in the business of insurance would be enacted, including prohibitions against: (1) overvaluing or providing false reports to regulatory officials; (2) stealing money, funds, premiums, credits, or other property of another; (3) keeping false books, reports, or statements which relate to the financial condition of an insurer; and (4) improperly influencing or impeding the administration of the law;

[3] To view the three Grand Jury reports and recommendations in their entirety, go to the web site for the Office of the Statewide Prosecutor [http://legal.firn.edu/swp/index.html] and select the appropriate grand jury report.

- The Attorney General, a state attorney, or the Department of Insurance would be authorized to sue persons committing insurance fraud for civil monetary penalties;
- Persons engaged in the business of insurance would be prohibited from notifying any person about the existence or contents of a subpoena for records of that person;
- The criminal penalties for patient brokering would be increased; and
- The Department of Insurance would be authorized to pay rewards to persons who provide information leading to the arrest and conviction of persons committing complex or organized crimes arising from violations of s. 440.105, F.S. or s. 817.234, F.S. and $250,000 from the Insurance Commissioner's Regulatory Trust Fund would be appropriated to implement the reward program.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. The bill grants the Department of Insurance authority to make rules implementing the provisions of the bill relating to insurer anti-fraud plans. The bill also grants the Department of Insurance the authority to "establish procedures" to implement the Anti-Fraud Reward Program. It is not clear whether the Department would do this through the rulemaking process.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes. The bill would require private insurers to amend their anti-fraud plans and file amendments with the Department of Insurance by July 1, 2000. The bill would also require HMOs to file anti-fraud plans and bring HMOs within the definition of insurer for insurance fraud purposes. The bill would require the Department of Insurance to implement an Anti-Fraud Reward Program.

(3) any entitlement to a government service or benefit?

Yes. Persons who provide information leading to the arrest and conviction of a person for insurance fraud could receive a monetary reward.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

      N/A

   b. Does the bill require or authorize an increase in any fees?

      N/A

   c. Does the bill reduce total taxes, both rates and revenues?

      N/A

   d. Does the bill reduce total fees, both rates and revenues?

      N/A

   e. Does the bill authorize any fee or tax increase by any local government?

      N/A

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      N/A

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      N/A

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      No. Private insurers, including HMOs, would be required to file detailed anti-fraud plans with the Department of Insurance. In addition, the bill would extend the statute of limitations for prosecuting insurance fraud, which would subject persons to potential prosecution for a longer period of time.

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      N/A

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

         N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

The bill amends ss. 624.418, 626.989, 626.9891, 627.411, 775.15, 817.234, 817.505, F.S.; creates ss. 626.9892, 641.3915, 817.2341, 817.2342, 817.2343, and 817.2344, F.S.; and reenacts ss. 455.657(3), 464.018(1)(d), 772.102(1), and 895.02(1), F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 624.418, F.S. Under current law, the Department of Insurance is authorized to suspend or revoke an insurer's certificate of authority if it finds that the insurer: is in unsound financial condition; transacts business in a manner that is hazardous to its policyholders or the public; failed to pay a final judgment; or no longer meets the requirements for a certificate. See s. 626.989(6), F.S.

This section would grant the Department specific authority to suspend or revoke an insurer's certificate of authority for failure to comply with the insurance fraud reporting requirements and the requirements relating to insurer anti-fraud plans and special investigative units.

Section 2: Amends s. 626.989, F.S. Under current law, s. 626.989, F.S., establishes the Division of Insurance Fraud ("Division") within the Department of Insurance, defines "fraudulent insurance act," sets forth the Division's authority, and establishes requirements that insurers and other persons report knowledge of insurance fraud to the Division. Presently, the Division's investigatory authority includes fraudulent insurance acts or violations of s. 626.9541 (unfair insurance trade practices), s. 817.234 (false and fraudulent claims), or s. 624.215 (general penalty for willful violations of the insurance code).

For purposes of what constitutes a "fraudulent insurance act," this section would expand the definition of "insurer" and "insurance policy" to include HMOs and HMO subscriber contracts. This section would broaden the investigatory authority of the Division by including violations of ss. 817.2341 and 817.2343, F.S. (new sections created in the bill -- see sections 9 and 11). Lastly, this section would also expand the insurance fraud reporting requirements to include violations of ss. 817.2341 and 817.2342, F.S. (new sections created by the bill -- see sections 9 and 10) and s. 440.105, F.S. (workers' compensation fraud).

Section 3: Amends s. 626.9891, F.S. Under current law, insurers that write more than $10 million in direct written premium are required to establish a special investigative unit ("SIU") within the company or contract with others to investigate insurance fraud. Insurers are required to file with the Department a description of the SIU established by the insurer. For insurers that write less than $10 million in direct written premiums, current law requires insurers to adopt and file with the Department an insurer anti-fraud plan. Insurer anti-fraud plans are presently required to include a description of: the insurers procedures for detecting fraud; the procedures for mandatory reporting of fraudulent insurance acts; the insurer's plan for anti-fraud education of its personnel; and the personnel responsible for the investigating and reporting of insurance fraud.

This section would substantially rewrite this provision of law. It would require all insurers, regardless of the amount of premium written and regardless of whether a SIU had been established, to adopt and file an anti-fraud plan with the Department by July 1, 2000 (insurers with previously filed plans would be required to amend their plan and refile). This anti-fraud plan would be required to include a description of:

- *the SIU or a copy of the contract for investigating fraud, if applicable;*
- *the procedures facilitating the detection and investigation of fraudulent insurance acts, including specific policy provisions and procedures relating to health, property, life, casualty, and workers' compensation and employer's liability;*
- *the procedures for mandatory reporting of fraudulent insurance acts to the Department;*
- *the procedures for auditing workers' compensation insureds to verify covered employees and to ensure proper classification. loss experience, and premium collection practices;*
- *the anti-fraud education and training plan, by line of business, for anti-fraud personnel; and*
- *the organizational chart of anti-fraud personnel and the experience of such personnel.*

This section would also authorize the Department to recommend changes or amendments to the anti-fraud plans and requires insurers to describe the resources allocated to identify and combat fraud. Lastly, this section grants rulemaking authority to the Department to implement the provisions of this section, including requirements that material be submitted on a form prescribed by the Department.

Section 4: Creates s. 626.9892, F.S. Under current law, persons are authorized to report information relating to insurance fraud to the Division without fear of civil liability for libel. slander, or another relevant tort. However, current law does not provide any incentives for the reporting of information relating to insurance fraud.

This section would create the Anti-Fraud Reward Program. Under this section, the Department would be authorized to pay rewards of up to $25,000 from the Insurance Commissioner's Regulatory Trust Fund to persons responsible for providing information leading to the arrest and conviction of persons committing complex or organized crimes investigated by the Division arising under s. 440.105, F.S. (workers' compensation fraud) or s. 817.234, F.S. (false and fraudulent claims). This section would provide that only a single reward may be awarded regardless of the number of persons arrested and regardless of how many persons submit claims for the reward. This section would also authorize the Department to establish procedures to implement and administer the Anti-Fraud Reward Program.

All "procedures, determinations, and other actions of the department" under this section would be exempt from the Administrative Procedure Act, ch. 120, F.S. This exemption from chapter 120 would apparently apply both to determinations of awards and to rulemaking.

Section 5: Adds paragraph (e) to subsection (2) of s. 627.411, F.S. Under current law, the Department regulates the benefits paid by insurers to ensure they are reasonable in relation to the premiums charged. Section 627.411, F.S., sets forth the grounds for disapproval of benefits paid by the insurer. In making such a determination, current law requires the Department to consider past and prospective loss experience, allocation of expenses, risk and contingency margins, and acquisition costs.

This section would authorize the Department to also consider all other relevant factors which impact the frequency or severity of claims or expenses.

Section 6: Creates s. 641.3915, F.S. *This section would require HMOs to comply with the requirements of s. 626.9891, F.S., relating to anti-fraud plans and investigative units, the same as any other insurer.*

Section 7: Amends s. 775.15, F.S. Presently, the statute of limitations for prosecuting insurance fraud is established by the general statute of limitations for felonies other than first degree felonies -- which is 3 years. The statute of limitations for workers' compensation fraud (violations of s. 440.105, F.S.) was changed by the Legislature in 1998 from 3 years to 5 years.

This section would extend the statute of limitations from 3 to 5 years for prosecutions of violations of ss. 817.234 (false and fraudulent insurance claims), 817.2341 (provision created by the bill relating to fraud by persons engaged in the business of insurance), and 817.2343, F.S. (provision created by the bill relating to the obstruction of justice). See sections 9 and 11 for a discussion of these new provisions.

Section 8: Amends s. 817.234, F.S., relating to fraudulent insurance claims and applications. *The bill would reclassify the various offenses contained in this section as "insurance fraud" and would provide a sliding scale of penalties based on the amount involved instead of the third-degree felony penalties that currently apply to these offenses. When the amount involved in the violation is less than $20,000, the act would remain a third degree felony, as under current law. When the amount involved is $20,000 or more, but less than $100,000, the act would be a second degree felony, and when the amount involved is $100,000 or more, the act would be a first degree felony. A second degree felony is punishable by up to 15 years in prison and a fine of up to $10,000, and a first degree felony is punishable by up to 30 years and a fine of up to $10,000.*

Section 9: Creates s. 817.2341, F.S. In the Grand Jury report relating to insolvency fraud, the Grand Jury noted that current Florida statutes do not adequately address the problems associated with investigating and prosecuting insolvency fraud.

This section would prohibit any person engaged in the business of insurance from knowingly, or with the intent to deceive, making any false material statement or report or willfully overvalue any land, property, or security, in connection with any financial reports or documents presented to any insurance regulatory official or agency.

This section would also prohibit any officer, director, agent, or employee of any person engaged in the business of insurance from knowingly obtaining or using the property of another with the intent to temporarily or permanently deprive such person of any moneys, funds, premiums, credits or other property of such person in an insurance transaction. This section would define this activity as a "fraudulent insurance act."

In addition, this section would prohibit any person engaged in the business of insurance, in a transaction relating to the conduct of the affairs of such business, from knowingly making any false entry of a material fact in any book, report, or statement with the intent to deceive any person about the financial condition or solvency of the business.

This section would establish a sliding penalty schedule based on the amount involved in each of these violations. When the amount involved in the violation is less than $20,000, the act would be a third degree felony. When the amount involved is $20,000 or more, but less than $100,000, the act would be a second degree felony, and when the amount involved is $100,000 or more, the act would be a first degree felony.

Lastly, this section would prohibit any person from corruptly influencing, obstructing, or impeding the administration of the law relating to any proceeding involving the business of insurance before any insurance regulatory official or agency or any agent or examiner appointed by such official or agency. This section would designate such an act as a second degree felony which would also warrant fines as provided in s. 817.2342, F.S. (new provision created in section 10 of the bill).

Section 10: Creates s. 817.2342, F.S. *This section would authorize the Attorney General, a state attorney, or the Department of Insurance to bring a civil lawsuit in circuit court against any person who commits a violation of s. 817.2341, F.S. (new provision created in section 9 of the bill) and recover a civil penalty of up to $50,000 for each violation or the amount of the compensation the person received or offered for the prohibited conduct, whichever is greater. The standard of proof for a recovery under this section would be preponderance of the evidence. If the violation by the person contributed to an order of conservation, rehabilitation, or liquidation of an insurer, the penalty shall be remitted to the appropriate regulatory official for the benefit of the policyholders, claimants, and creditors of such insurer. This section also authorizes the Attorney General, a state attorney, or the Department of Insurance to petition a court to prohibit a person from engaging in conduct that constitutes an offense under s. 817.2341.*

Section 11: Creates s. 817.2343, F.S. *This section would prohibit the obstruction of justice in connection with judicial proceedings or criminal investigations. It would prohibit the obstruction of justice under the following circumstances:*

- *Any officer, director, agent or employee of a person engaged in the business of insurance; any person engaged in the business of insurance; or any person involved in a transaction relating to the conduct of affairs of such a business,*
- *with the intent to obstruct a judicial proceeding or criminal investigation,*
- *shall not directly or indirectly notify any other person about,*
- *the existence or contents of a subpoena for records of that person; or*
- *information that has been furnished to the Attorney General, a state attorney, the Department of Insurance or a grand jury in response to that subpoena.*

Section 12: Creates s. 817.2344, F.S. *This section would provide definitions for the terms, "business of insurance," "insurer," "obtains or uses," "property," subpoena for records," and "value" used in ss. 817.2341-817.2344, F.S. This section would also provide that the provisions of ss. 817.2341, 817.2342, 817.2343, and 817.2344 shall not be construed to preclude the applicability of other criminal laws with apply to violations of these sections.*

Section 13: Amends s. 817.505, F.S. Under current law, it is unlawful for any person, including any health care provider or health care facility, to

- offer or pay any commission, bonus, rebate, kickback or bribe or engage in any split-fee arrangement to induce the referral of patients or patronage from a health care provider or health care facility;

- solicit or receive any commission, bonus, rebate, kickback or bribe or engage in any split-fee arrangement in return for referring patients or patronage from a health care provider or health care facility;

These violations are referred to as "patient brokering." The current penalty for violations of this section are: a first degree misdemeanor for the first violation and a third degree felony for subsequent violations. See s. 817.505(4)(a) and (b), F.S.

This section of the bill would revise the law so that all violations of this section, including first violations, are third degree felonies.

Section 14: Reenacts s. 455.657(3), F.S., relating to prohibited kickbacks, for the purpose of incorporating the proposed change to s. 817.505 (see section 13, above).

Section 15: Reenacts ss. 464.018(1), 772.102(1), and 895.02(1), F.S., for the purpose of incorporating the bill's proposed creation of ss. 817.2341 and 817.2342, F.S., and references thereto.

Section 16: *Would appropriate $250,000 from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance to implement "the purpose and provisions of funding" the Anti-Fraud Reward Program (see section 4, above).*

Section 17: Provides an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

The bill would appropriate $250,000 from the Insurance Commissioner's Regulatory Trust Fund in a nonoperating category for state fiscal year 1999-2000 to implement the Anti-Fraud Reward Program.

2. Recurring Effects:

According to a fiscal analysis prepared by the Department of Insurance, this bill would have no recurring fiscal impact on the Department.

3. Long Run Effects Other Than Normal Growth:

N/A

4. Total Revenues and Expenditures:

N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

N/A

2. Recurring Effects:

N/A

3. Long Run Effects Other Than Normal Growth:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

The bill would require all insurers to file amendments to their anti-fraud plans with the Department of Insurance by July 1, 2000. Thus, insurers would be required to incur costs associated with amending and refiling the anti-fraud plans. The bill would also require all HMOs to prepare and file anti-fraud plans with the Department of Insurance. Since HMOs are not currently required to file anti-fraud plans, HMOs would incur costs in preparing and filing plans.

2. Direct Private Sector Benefits:

   To the extent the bill's provisions result in fewer incidents of insurance fraud, the bill could lower the number of insurer insolvencies due to fraud, reduce the amount of money spent by health insurers and HMOs on health scams, and ultimately could lower the cost of insurance to consumers.

3. Effects on Competition, Private Enterprise and Employment Markets:

   N/A

D. FISCAL COMMENTS:

N/A

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

A. APPLICABILITY OF THE MANDATES PROVISION:

N/A

B. REDUCTION OF REVENUE RAISING AUTHORITY:

N/A

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

N/A

V. COMMENTS:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
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