STORAGE NAME: h1743s1a.jud
DATE: April 16, 1999

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
JUDICIARY
ANALYSIS

BILL #: CS/HB 1743

RELATING TO: Insurance Fraud

SPONSOR(S): Committee on Insurance, Rep. Wiles and Rep. Cosgrove

COMPANION BILL(S):

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

(1) INSURANCE YEAS 11 NAYS 0
(2) JUDICIARY YEAS 9 NAYS 0
(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 and establish SIUs;
- HMOs and HMO contracts would be included under the law prohibiting false and fraudulent insurance claims and applications (s . 817.234, F.S.); and
- The criminal penalty for first offenses of "patient brokering" provisions would be increased.

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).

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

Rewards

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.

[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.

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.

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;
- HMOs and HMO contracts would be included under the law prohibiting false and fraudulent insurance claims and applications (s . 817.234, F.S.);
- Like any other insurer, HMOs would be required to file anti-fraud plans and implement special investigative units;
- 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:

[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.

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 HMOs to file anti-fraud plans with the Department of Insurance. 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. HMOs would be required to file anti-fraud plans and establish special investigative units.

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 committee substitute amends ss. 626.989, 775.15, 817.234, 817.505, F.S.; creates ss. 626.9892 and 641.3915, F.S.; and reenacts s. 455.657(3), F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1: 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). This section also provides limited immunity from civil liability to persons who provide information to the Division relating to insurance fraud and to persons within special investigative units (SIUs) who share information with other persons relating to insurance fraud.

Commensurate with the bill's requirement that HMOs establish SIUs (see section 3), this section would extend to HMOs the limited civil immunity contained in s. 626.989(4), F.S.

Section 2: 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 (which may be disbursed to more than one person) may be paid for claims arising out of the same transaction and occurrence, regardless of the number of persons arrested and convicted and regardless of the number of persons submitting claims for the reward. This section would also authorize the Department to adopt rules which set forth the application and approval process, including the criteria for evaluating claims, the basis for determining award amounts, and the manner in which rewards will be disbursed.

This section would also provide that determinations by the Department to grant or deny a reward would not be considered agency action for purposes of review under the Administrative Procedure Act, ch. 120, F.S.

Section 3: 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 4: 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 s. 817.234, F.S. (false and fraudulent insurance claims).

Section 5: 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. This section would also expand the definition of insurer to include HMOs and HMO subscriber and provider contracts for purposes of s. 827.234, F.S.

Section 6: 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 7: 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 6, above).

Section 8: *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 2, above).*

Section 9: 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 HMOs to file anti-fraud plans with the Department of Insurance and establish SIUs. Since HMOs are not currently required to file anti-fraud plans and establish SIUs, HMOs would incur costs in preparing and filing plans and in establishing SIUs. However, these costs could be offset to the extent these new anti-fraud plans and SIUs result in reducing the costs associated with fraudulent practices and claims.

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:

Judiciary Committee staff comments

While Section 2 indicates that determinations by the Department to grant or deny a reward will not to be considered agency action subject to Chapter 120, the process by which the rules are promulgated will be governed by Chapter 120. In addition, it is unlikely that individuals contesting a reward will be left without a remedy; these actions will most likely be brought in circuit court.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 29, 1999, the Committee on Insurance adopted a strike-everything amendment to HB 1743. The strike-everything amendment was adopted and the bill approved as a committee substitute. The committee substitute differs from the original bill in that it retains several provisions from the original bill, deletes several provisions from the original bill, and adds one new section. The new section of the bill relates to extending the limited civil immunity to HMOs for establishing SIUs. The provisions deleted from the original bill include:

- Authority for the Department of Insurance to suspend the license of an insurer for failing to follow insurance fraud reporting requirements;
- The inclusion of HMOs in the definition of "insurer" for purposes of the definition of "fraudulent insurance act" under s. 626.989(1), F.S.;
- The requirement that the Department consider all other relevant factors when approving health insurance benefits;
- The provisions relating to insurance fraud by persons engaged in the business of insurance, 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;
- Authority for the Attorney General, a state attorney, or the Department of Insurance to sue persons committing insurance fraud for civil monetary penalties; and
- The prohibition against persons engaged in the business of insurance from notifying any person about the existence or contents of a subpoena for records of that person.

On April 15, 1999, the Committee on judiciary passed three amendments to the bill. Amendment 1 requires in the case of licensure covering only credit life or disability insurance, an entity is : (1) required to submit only one application for license; (2) required to obtain a license for each office, branch office, or place of business; and (3) is not required to pay any additional application fees for each of the licenses required by (2).

Amendment 2 includes health maintenance organizations within the term "insurer" and health maintenance subscriber contracts within the term "insurance policy."

Amendment 3 concerns health maintenance organization anti-fraud plans and requires HMO's to comply with sections 626.989 and 626.9891 as though the organization or applicant was an authorized insurer.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Robert E. Wolfe, Jr.	Stephen Hogge

AS REVISED BY THE COMMITTEE ON JUDICIARY:

Prepared by:	Staff Director:
Jo Ann Levin	Don Rubottom