SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: April 20, 1998 Revised: _____ _____ _____ _____

Subject: Insurance Fraud

	Analyst	Staff Director	Reference	Action
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			CJ	
3.			WM	
4.				
5.				

I. Summary:

This committee substitute would revise statutory provisions relating to insurance fraud. It provides for the following:

- Persons who commit specified acts of criminal insurance fraud would be subject to third-degree, second-degree or first-degree felony penalties depending on the value of the money or property involved in the offense. The statute of limitations provisions would be lengthened from 3 to 5 years.

- Insurers and Health Maintenance Organizations (HMOs) would be required to establish anti-fraud units and submit anti-fraud plans and reports to the Department of Insurance.

- The jurisdiction of the Division of Insurance Fraud would be expanded to include all criminal violations of HMO fraud. Additionally, criminal prohibitions against false and fraudulent insurance claims and applications would be expanded to include HMOs.

- For purposes of immunity from civil liability, the term “designated employees of insurers,” would be expanded to include employees of the entity with whom the insurer contracts to investigate insurance fraud under s. 626.9891, F.S.

- The Department of Insurance would be able to pay rewards of up to $25,000 to persons who provide information leading to the arrest and conviction of persons who commit complex and organized crimes which are investigated by the Division of Insurance Fraud and which arise from violations of the insurance code or the workers’ compensation code or from violations of the law prohibiting false and fraudulent insurance claims and applications. The committee substitute provides for an exemption from the Administrative Procedures Act, chapter 120, F.S., as to rulemaking and determinations of awards.

- An appropriation of $250,000 from the Insurance Commissioner's Regulatory Trust Fund would be provided to fund the reward program.

This bill substantially amends the following sections of the Florida Statutes: 626.989, 626.9891, 626.9892, 641.3915, and 817.234.

II. Present Situation:

Division of Insurance Fraud

The Division of Insurance Fraud is a law enforcement agency which was established in 1976 within the Department of Insurance. Pursuant to ss. 20.13 and 626.989, F.S., the division has the statutory duty to investigate "fraudulent insurance acts" (materially false and fraudulent statements or claims to or by an insurer),[1] violations of s. 626.9541, F.S. (unfair insurance trade practices), violations of s. 817.234, F.S. (false and fraudulent insurance claims and applications), 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).[2] Additionally, the division has the authority to investigate criminal violations of the workers' compensation law after receiving a report of a violation from an insurer, a professional practitioner, or other specified parties.[3]

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. According to the reports submitted to the Division of Insurance Fraud, 1,073 insurers have established anti-fraud units (special investigative units), 177 insurers have contracted with a vendor to provide the services of an anti-fraud unit, and 283 insurers have established anti-fraud plans.

The above requirements do not apply to a health maintenance organization (HMO), because an HMO is not defined to be 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.

Civil Immunity

Under s. 626.989, F.S., designated employees of insurance companies who investigate fraudulent insurance acts may share information relating to persons suspected of committing insurance fraud with designated employees of other insurance companies and, in the absence of fraud or bad faith, such employees are not subject to civil liability for libel, slander, or other relevant tort. However,

[1] See the definition of "fraudulent insurance act" in s. 626.989(1), F.S.

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

[3] Section 440.105(1)(a), F.S.

it is unclear whether this immunity provision is available for third parties who contract with insurers to provide anti-fraud investigative services under s. 626.9891, F.S.

Criminal penalties and statute of limitations

Violations of s. 817.234, F.S. (false and fraudulent insurance claims and applications) are third-degree felonies, 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.

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.[4]

III. Effect of Proposed Changes:

Section 1. Amends s. 626.989, F.S., to provide that for purposes of the jurisdiction of the Division of Insurance Fraud, a Health Maintenance Organization (HMO) is to be considered an insurer, and a HMO subscriber contract is to be considered an insurance policy. For purposes of immunity from civil liability, the committee substitute also defines the term "designated employees of insurers" to include employees of the entity with whom an insurer may contract to investigate insurance fraud under s. 626.9891, F.S.

Section 2. Amends s. 626.9891, F.S., relating to insurer anti-fraud plans and reports and anti-fraud units. This section would require all insurers (including insurers required to establish anti-fraud units or to contract with others to investigate fraud) to file or refile anti-fraud plans by January 1, 1999. Current requirements for anti-fraud plans would be expanded by adding a requirement that the plan specify the policy provisions and investigative procedures intended to combat "complex instances of insurance fraud" in the areas of health, property, casualty, workers'

4 See, e.g., ss. 106.24, 212.0515, 372.073, 372.911, 373.614, 590,15, 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 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.

compensation and employer's liability insurance, and by adding a requirement that the plan specify procedures for auditing workers' compensation insureds. The committee substitute would require insurers to file anti-fraud reports with the department prior to March 1, 2000, and annually thereafter. Such reports would include amendments to an insurer's anti-fraud plan, a statement of the insurer's total number of referrals of suspected fraud to the division by line of coverage and monetary category as well as the amount of resources allocated to identify and combat fraud.

Section 3. Creates s. 626.9892, F.S., relating to the Anti-Fraud Reward Program. This section creates the Anti-Fraud Reward Program within the Department of Insurance, to be funded from the Insurance Commissioner's Regulatory Trust Fund. The department would be authorized to pay rewards of up to $25,000 to persons who provide information leading to the arrest and conviction of persons committing "complex and organized crimes" which are investigated by the Division of Insurance Fraud and which arise from violations of the Insurance Code, section 440.105 (specified workers' compensation violations), or section 817.234 (false and fraudulent insurance claims and applications). The term "complex and organized crimes" is not defined.

Only one reward could be awarded for a particular case, regardless of the number of people involved in the crime or the number of people submitting claims for the reward. The department would adopt procedures for applications for rewards. The department would be required to adopt "procedures to implement and administer" the program. The decision as to whether to offer a reward as well as the amount of the reward 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 4. Creates s. 641.3915, F.S., relating to anti-fraud units, plans and reports of Health Maintenance Organizations. This section would apply to HMOs, requirements similar to the anti-fraud plans and reports, and anti-fraud unit provisions which apply to insurers (see section 2, above).

Section 5. Amends s. 817.234, F.S., relating to fraudulent insurance claims and applications. It would revise the criminal penalties for various offenses relating to insurance fraud depending on the value of the money or property involved in the offense. The term "insurer" would include a Health Maintenance Organization (HMO) and HMOs would be included in the term "insurance policy." This section would clarify certain offenses as either "insurance fraud" or "insurance solicitation," 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.

The bill would provide a 5-year statute of limitations for violations of s. 817.234, F.S., rather than the general 3-year and 4-year statutes of limitations applicable to most felonies. The statute of limitations would be tolled, i.e., suspended for up to an additional year while the defendant is outside of the state, and would also be tolled for the duration of a proceeding to punish, prevent, or restrain violations of s. 817.234, F.S., and for 2 years thereafter if that prosecution is based on the same matters as the prosecution of the defendant.

Section 6. Appropriates $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 3, above).

Section 7. Provides that the bill will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would create costs of compliance with a new requirement that insurers and HMO's establish anti-fraud units or contract with others to investigate fraud, as well as file anti-fraud plans, and annually, anti-fraud reports, with the Department of Insurance.

The bill would allow the Department of Insurance to recommend changes or amendments to an insurer's or HMO's anti-fraud plan.

The bill could reduce the incidence of insurance fraud, including workers' compensation fraud. A reduction in fraud costs absorbed by insurers could result in rate reductions, or reduced pressure to increase rates.

C. Government Sector Impact:

Expenditure FY 1998-99

Ins. Comm. Reg. Trust Fund (Reward Program): $250,00

The department estimates that it will need three staff positions ($87,038 for FY 1998-1999) and $25,000 for contractual services for software programing to install a database for the reporting requirements pursuant to sections 2 and 4, above.

The committee substitute may result in increase costs to the criminal justice system since the penalties for insurance fraud have been increased.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.