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.)

BILL: CS/SB 2516

SPONSOR: Banking and Insurance Committee and Senator Rossin

SUBJECT: Insurance Fraud

DATE: April 19, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Fav/CS
2.			AG	
3.				
4.				
5.				

I. Summary:

The Division of Insurance Fraud within the Department of Insurance is tasked with investigating criminal insurance fraud. In December 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 committee substitute would make a variety of changes to Florida law relating to insurance fraud and would adopt several of the Grand Jury's recommendations. The bill's provisions include the following:

- 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 or establish special investigative units;
- HMOs and HMO subscriber contracts would be included under the law prohibiting false and fraudulent insurance claims and applications; 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.

Additionally, the bill would facilitate licensing and appointment procedures for entities offering credit property, credit life, credit disability, and credit insurance.

The bill substantially amends the following sections of the Florida Statutes: 626.321, 626.989, 775.15, 817.234, and 817.505. The bill creates the following sections of the Florida Statutes: 626.9892, and 641.3915. The bill reenacts section 455.657(3) of the Florida Statutes.

II. Present Situation:

Division of Insurance Fraud

The Division of Insurance Fraud 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.” Additionally, s. 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. This provision does not apply to employees of HMOs.

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.

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

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

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/Recommendations

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 persons around the state and 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. 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 changes and several are incorporated into this committee substitute.[3] They are the following:

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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.

[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.

- 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;
- Like any other insurer, HMOs would be required to file anti-fraud plans or establish 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 certain violations and $250,000 from the Insurance Commissioner's Regulatory Trust Fund would be appropriated to implement the reward program.
- Other recommendations (not addressed by this bill).

Credit Insurance

Currently, financial institutions such as banks, loan finance companies, and credit card companies offer credit insurance that pays for the credit holder's debt in case of disability or death. Credit disability pays if the person becomes disabled while credit life insurance pays if the person dies. Credit property insurance provides coverage on personal property used as collateral for a loan. Licenses to sell such insurance are issued to entities, such as finance companies or auto dealerships, enabling any employee of the entity to sell the coverage. Such entities are licensed by the Department of Insurance.

III. Effect of Proposed Changes:

Section 1. Amends s. 626.321, F.S., relating to credit life or disability insurance licenses, to permit entities, other than financial institutions as defined in s. 626.988, F.S., to be licensed to market credit life insurance, including credit disability, credit property and credit insurance. It allows entities applying for licensure under this provision to submit only one application, obtain a license for each branch office, and apply for licensure using an abbreviated or simplified application form. Additionally, such entities are not required to pay any additional application fees for a license issued to a branch office, but are required to pay certain appointment fees. It further requires posting of the license at the business location.

Section 2. Amends s. 626.989(1), F.S., 1998 Supplement, relating to the authority of the Division of Insurance Fraud, to provide that for purposes of the jurisdiction of the division, a health maintenance organization (HMO) is to be considered an "insurer," and a HMO subscriber contract is to be considered an "insurance policy." This provision would extend to HMOs the limited civil immunity contained in s. 626.989(4), F.S. That limited immunity from civil liability provision applies to persons who provide confidential 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.

Section 3. Creates s. 626.9892, F.S., establishing 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 or organized crimes" which are investigated by the Division of Insurance Fraud and which arise from violations of s. 440.105 (refers to criminal workers' compensation violations); s. 624.15 (refers to willful violations of the Insurance Code); s. 626.9541 (refers to unfair methods of competition and unfair or deceptive acts); s. 626.989 (refers to fraudulent insurance acts); or, s. 817.234 (false and fraudulent insurance claims and applications). The term "complex or organized crimes" is not defined.

Only one reward could be awarded for a particular claim arising out of the same transaction, regardless of the number of persons arrested and convicted or the number of persons submitting claims for the reward. The department is mandated to adopt rules that set forth the application and approval process, including criteria against which claims are to be evaluated, the basis for determining specific reward amounts, and the manner in which rewards are disbursed. Applications for rewards would be made under rules established by the department. The decision by the department to grant or deny a reward is not considered agency action and is therefore exempt from the Administrative Procedures Act, ch. 120, F.S.

Under current law, persons may report information relating to insurance fraud to the Division of Insurance Fraud 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 to the department.

Section 4. Creates s. 641.3915, F.S. This section would require HMOs and applicants for a certificate of authority to comply with the requirements of s. 626.9891, F.S., within certain time frames as though such entities were authorized insurers. In 1995, the Legislature enacted s. 626.9891, F.S., which mandated insurance companies, depending on the amount of their direct premiums written, to either establish special investigative units or submit anti-fraud plans to the Division of Insurance Fraud, within certain time frames prescribed in the law. (ch. 95-340, L.O.F.).

Section 5. Amends s. 775.15, F.S., 1998 Supplement, relating to the criminal statute of limitations. Presently, the statute of limitations for prosecuting insurance fraud is established by the statute of limitations for felonies, other than first degree felonies, which is 3 years. Last year, the statute of limitations for workers' compensation insurance fraud (violations of s. 440.105, F.S.) was increased from 3 to 5 years (ch. 98-174, L.O.F.). This section extends the statute of limitations from 3 to 5 years for prosecutions of violations of s. 817.234, F.S. (false and fraudulent insurance claims and applications).

Section 6. Amends s. 817.234, F.S., relating to fraudulent insurance claims and applications. The committee substitute would clarify that the various criminal offenses contained in this section are "insurance fraud" and would provide a sliding scale of penalties based on the value of the money or property involved in the offense. When the value of any property involved in a violation of this section 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 third degree felony is punishable by up to 5 years in prison and a fine of $5,000,

while a second degree felony is punishable by up to 15 years in prison and a fine of up to $10,000. A first degree felony is punishable by up to 30 years and a fine of up to $10,000. Health maintenance organization subscriber or provider contracts would be included within the fraudulent insurance claims provisions and the term “insurer” would include a HMO.

Section 7. Amends s. 817.505, F.S., 1998 Supplement, relating to patient brokering. 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 committee substitute would revise the law so that all violations of this section, including first violations, are third degree felonies.

Section 8. Reenacts s. 455.657(3), F.S., relating to prohibited kickbacks, for the purpose of incorporating the proposed amendment to s. 817.505, F.S., (see section 7, above) within s. 455.657(3), F.S.

Section 9. Appropriates $250,000 from the Insurance Commissioner’s Regulatory Trust Fund in a nonoperating category for FY 1999-2000 to the Department of Insurance to implement the Anti-Fraud Reward Program (see section 3, above).

Section 10. Provides an effective date of July 1, 1999.

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:

Representatives with the Department of Insurance state that the licensing fees required for entities under the credit insurance provisions of the committee substitute will be revenue neutral for the department.

B. Private Sector Impact:

The committee substitute would create costs of compliance for all HMOs to either file anti-fraud plans with the Department of Insurance or establish special investigative units. Health maintenance organizations would benefit because their designated employees would be able to share confidential insurance fraud information with other insurers and certain insurance fraud violations would become violations against HMOs. Also, the effect of the committee substitute could reduce the incidence of insurance fraud since the penalties are significantly increased.

Entities applying for licensure pertaining to various types of credit insurance (credit property, credit life, and credit disability insurance) will benefit by having to file one application form with the department and pay reduced fees.

C. Government Sector Impact:

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

The Department of Insurance would have to promulgate rules pertaining to the Anti-Fraud Reward Program. Representatives with the department estimate that the following expenditure relating to the Reward Program will impact the Insurance Commissioner's Regulatory Trust Fund.

Insurance Commissioner's Reg. Trust Fund	**FY 1999-2000**
Expenditure (Anti-Fraud Reward Program)	**$250,000**

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.