The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1012
INTRODUCER:	Senator Brandes
SUBJECT:	Investigative and Forensic Services
DATE:	March 31, 2017
REVISED:	

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

I. Summary:

SB 1012 creates new requirements for insurance companies relating to insurance fraud prevention and reporting. The bill requires insurers writing $10 million in premium to adopt an anti-fraud plan and to establish and maintain a unit within the company to investigate possible fraudulent insurance acts or contract with others to investigate fraudulent insurance acts. The insurer must electronically file with the Department of Financial Services (DFS) a detailed description of the unit established to investigate possible fraudulent insurance acts or a copy of the contract with the company that investigates fraudulent insurance acts for the insurer. This filing must be made annually on or before September 1, starting in 2017.

An insurer writing less than $10 million in premium must adopt an anti-fraud plan and file it electronically with the DFS on or before September 1, 2017, and annually thereafter. An insurer may, in lieu of adopting and filing an anti-fraud plan, contract with others to investigate possible fraudulent acts.

The bill requires every insurer to submit anti-fraud statistics to the DFS annually by September 1 for the lines written by that insurer for the calendar year. The statistics must include:

- The number of policies in effect;
- The amount of premiums written for policies;
- The number of claims received;
- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the DFS;

- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount of damages in cases referred to the DFS or other agencies.

Current law only requires statistical reporting from workers' compensation insurers. This bill requires all insurers to provide reports.

The bill provides that funds appropriated by an operating appropriation or a nonoperating transfer from the Workers' Compensation Administration Trust Fund to the Justice Administrative Commission remaining unencumbered as of June 30 or undisbursed as of September 30 each year do not revert back to the fund.

The bill creates a dedicated prosecutor program to be administered by the DFS. The program will allow state attorneys to seek grants from DFS, subject to funding by the Legislature, to add positions to prosecute insurance fraud cases.

II. Present Situation:

The DFS regulates insurance agents, insurance agencies, and insurance adjusters. The DFS Division of Investigative and Forensic Services (division) contains sworn law enforcement officer that investigate various types of insurance fraud including personal injury protection (PIP) fraud, workers' compensation fraud, vehicle fraud, application fraud, licensee fraud, homeowner's insurance fraud, and healthcare fraud. The division is directed by statute to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act, false and fraudulent insurance claims, and willful violations of the Florida Insurance Code and rules adopted pursuant to the code. The division employs sworn law enforcement officers to investigate insurance fraud and other matters within the division's jurisdiction. In Fiscal Year 2014-2015, the division received 17,392 referrals.[1]

Workers' Compensation Administration Trust Fund

Section 440.50, F.S., creates the Workers' Compensation Administration Trust Fund (fund). The fund provides for the payment of all expenses in respect to the administration of ch. 440, F.S., including the vocational rehabilitation of injured employees, the funding of fixed administrative expenses, and the funding of the Bureau of Workers' Compensation Fraud within the DFS.[2] Funds appropriated by an operating appropriation or a nonoperating transfer from the fund to the Agency for Health Care Administration, the Department of Business and Professional Regulation, the Department of Management Services, the First District Court of Appeal, and the Justice Administrative Commission remaining unencumbered as of June 30 or undisbursed as of September 30 each year revert to fund.[3]

[1] http://www.fldfs.com/Division/DIFS/resources/documents/2014-15_Annual-Report.pdf (last accessed March 29, 2017).
[2] s. 440.50(1)(a), F.S.
[3] s. 440.50(5), F.S.

Anti-Fraud Requirements Imposed on Insurance Companies

Section 626.9891, F.S., requires each insurer admitted to do business in this state, if the insurer received $10 million or more in direct premiums during the previous calendar year, to establish a unit to investigate possible insurance claim fraud or to contract with others to investigate such fraud. The insurer must file a detailed description of the anti-fraud unit with, or provide a copy of the contract, to the division.[4]

If the insurer received less than $10 million in direct premiums during the previous calendar year, the insurer must submit an anti-fraud plan to the division.[5] The anti-fraud plan must describe:

- A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;
- A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the division;
- A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel; and
- A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.[6]

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

- The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other;
- The number of fraud referrals submitted to the Bureau of Workers' Compensation Fraud for the prior year;
- A description of the organization of its anti-fraud unit, if applicable;
- The rationale for the level of staffing and resources being provided for the SIU;
- The in-service anti-fraud education and training provided to personnel; and
- A description of a public awareness program focused on insurance fraud and methods by which the public can prevent it.[7]

If an insurer fails to comply with the requirements for anti-fraud units or anti-fraud plans or fails to comply other provisions of law, the DFS, OIR, or Financial Services Commission may impose certain administrative fines.[8]

Dedicated Prosecutor Program

The Dedicated Prosecutor Program was created in September of 2003. The first dedicated prosecutor position was jointly funded by the DFS, the Miami-Dade State Attorney's Office and

[4] s. 626.9891(1), F.S.
[5] s. 626.9891(2), F.S.
[6] s. 626.9891(3), F.S.
[7] s. 626.9891(6), F.S.
[8] s. 626.9891(7), F.S.

the Florida Automobile Joint Underwriting Association. As of June 30, 2016, the program has 36 full time positions with 20 dedicated prosecutors located in Jacksonville, Orlando, Miami-Dade, Tampa, West Palm Beach, Broward, and Ft. Myers. Four positions are devoted solely to worker's compensation fraud.[9]

III. Effect of Proposed Changes:

Workers' Compensation Administration Trust Fund

Section 1 of the bill provides that funds appropriated by an operating appropriation or a nonoperating transfer from the fund to the Justice Administrative Commission remaining unencumbered as of June 30 or undisbursed as of September 30 each year do not revert back to the fund.

Anti-Fraud Requirements Imposed on Insurance Companies

Section 2 rewrites s. 626.9891, F.S. It requires every insurer to designate at least one employee responsible for meeting the requirements of s. 626.9891, F.S.

The bill requires insurers writing $10 million in premium to adopt an anti-fraud plan and establish and maintain a unit within the company to investigate possible fraudulent insurance acts or contract with others to investigate fraudulent insurance acts. The insurer must electronically file with the division a detailed description of the unit established to investigate possible fraudulent insurance acts or a copy of the contract with the company that investigates fraudulent insurance acts for the insurer. This filing must be made annually on or before September 1 starting in 2017.

If an insurer wrote less than $10 million in premium, it must adopt an anti-fraud plan and file it electronically with the division on or before September 1, 2017, and annually thereafter. An insurer may, in lieu of adopting and filing an anti-fraud plan, contract with others to investigate possible fraudulent acts.

The anti-fraud plan must include:

- An acknowledgement that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance written by that insurer;
- An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to the division;
- An acknowledgement that the insurer provides anti-fraud education and training to its claims adjusters or other personnel;
- A description of the anti-fraud education and training which is provided to the designated anti-fraud investigative unit or contractor and which is designed to assist in identifying and evaluating instances of suspected fraudulent insurance acts in underwriting or claims activities;

[9] Department of Financial Services, *Analysis of SB 1012* (March 8, 2017) at p. 2.

- A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts;
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors; and
- A description of the insurer's public awareness efforts focused on the costs and frequency of insurance fraud and methods by which the public can prevent such fraud.

The bill requires every insurer to submit anti-fraud statistics annually by September 1 for the lines written by that insurer for the calendar year. The statistics must include:

- The number of policies in effect;
- The amount of premiums written for policies;
- The number of claims received;
- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the Division of Investigative and Forensic Services of the department;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount of damages in cases referred to the Division of Investigative and Forensic Services of the department, or other agencies.

Current law only requires statistical reporting from workers' compensation insurers. This bill requires all insurers to provide reports.

The bill requires workers' compensation insurers to report the following information each year:

- The estimated dollar amount of losses attributable to workers' compensation fraud delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;
- The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;
- The number of cases referred to the division, delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;
- The dollar amount of recoveries and losses attributable to workers' compensation fraud, delineated by the type of fraud: claimant, employer, provider, agent, or other type; and
- A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles 186 and descriptions of staffing.

The bill requires every insurer to provide at least 2 hours of initial anti-fraud training to the designated anti-fraud investigative unit or contractor and shall provide an annual 1-hour refresher

course that addresses detection, referrals, investigations, and reporting of suspected insurance fraud for the types of insurance lines written by the insurer. The insurer must also require the designated anti-fraud investigative unit or contractor to complete one hour of training annually provided by the department.

The bill requires an insurer who submits an application to obtain a certificate of authority after September 1, 2017, to comply with the anti-fraud requirements of the bill before receiving its certificate.

The bill provides for administrative fines if an insurer fails to timely submit the statistical reports required by the DFS.

Dedicated Prosecutor Program

The bill creates an insurance fraud dedicated prosecutor program. It creates a grant program to fund the program and gives the division the responsibility to administer appropriated funds for the purpose of funding attorney and paralegal positions assigned to the prosecution of insurance fraud. Funds for the program are subject to appropriation by the Legislature.

The bill requires a state attorney that seeks a grant to submit an application to the DFS detailing the proposed number of dedicated prosecutors and staff to be funded solely for the prosecution of insurance fraud. The DFS must award grants to applicants whose prosecutorial needs are substantiated by the department's internal metrics and data. The DFS may alter this allocation formula as necessary to achieve the most effective and efficient allocation of funds necessary to meet the purpose of the program. Each grant must be awarded to a state attorney's office for the full annual salary, including benefits, for each attorney and paralegal whose duties are solely dedicated to the prosecution of insurance fraud. The DFS will establish the maximum grant amount based on available funding.

The DFS is required to track, monitor, and report on the effectiveness and efficiency of each state attorney's office's use of the awarded funds. A state attorney's office which receives a grant must submit performance and output information as determined by the DFS. The DFS may rely upon any reporting metric it requires of grant recipients, including:

- Funds received and expended;
- The purposes for which those funds were expended, including payment of salaries, expenses, and any other costs needed to support the delivery of services; and
- The prosecutorial results achieved from the expenditures made, including the number of investigations, arrests, complaints filed, and convictions.

The bill gives the DFS rulemaking authority for the administration and implementation of the program. The rules may establish procedures for the program and forms to be used by the state attorney's office. The DFS may establish eligibility criteria, renewal requirements, and standards for evaluating the effectiveness and efficiency of expended funds.

Other Provisions

The bill amends s. 641.3915, F.S., to make technical changes.

The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurance companies will incur some costs compiling and providing statistical data to the DFS. The fiscal impact is not known.

C. Government Sector Impact:

The DFS anticipates an indeterminate negative fiscal impact on the Workers' Compensation Administration Trust Fund because it will no longer receive unexpended funds from the Justice Administrative Commission.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 440.50, 626.9891, and 641.3915.

This bill creates section 626.9896 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.