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HOUSE OF REPRESENTATIVES
COMMITTEE ON
FINANCIAL SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 3561

RELATING TO: Insurance fraud

SPONSOR(S): Committee on Financial Services and Representative Goode & others

COMPANION BILL(S): SB 1640 (s)

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

(1) FINANCIAL SERVICES YEAS 8 NAYS 0
(2) CRIME AND PUNISHMENT
(3) GOVERNMENTAL RULES AND REGULATIONS
(4) GENERAL GOVERNMENT APPROPRIATIONS
(5)

I. SUMMARY:

This bill would revise statutory provisions relating to insurance fraud.

Persons who commit specified acts of insurance fraud would be subject to second-degree or first-degree felony penalties, rather than being subject to the third-degree felony penalties that currently apply. 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.

Health Maintenance Organizations (HMOs) would be required to establish anti-fraud units or anti-fraud plans, and criminal prohibitions against false and fraudulent insurance claims and applications would be expanded to include HMOs.

The jurisdiction of the Division of Insurance Fraud of the Department of Insurance would be expanded to include all criminal violations of the workers' compensation law and HMO fraud.

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 insurance fraud.

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

II. SUBSTANTIVE RESEARCH:

A. 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" (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]

The division also 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] The jurisdiction of the division to investigate an act in the absence of such a report does not necessarily include all criminal violations of the workers' compensation law. Although certain prohibited acts[4] would fall within the definition of "fraudulent insurance acts," other violations, such as presenting fraudulent evidence of compliance with the requirement of maintaining workers' compensation coverage, presumably would not be covered since the presentation of such evidence would not appear to involve materially false and fraudulent statements to or by an insurer.

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 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.

Criminal penalties and statute of limitations

Violations of s. 817.234, F.S. (false and fraudulent insurance claims and applications) and s. 440.105(4), F.S. (specified workers' compensation violations) 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

[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.

[4] See s. 440.105(4), F.S.

(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. Longer statutes of limitations are provided for some crimes; for example, the statute of limitations for securities fraud is 5 years.[5]

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.[6]

Administrative Law Judges

Chapter 96-159, Laws of Florida, renamed the hearing officers of the Division of Administrative Hearings of the Department of Management Services as Administrative Law Judges.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) are regulated by the Department of Insurance under Chapter 641, F.S. Although there are substantial similarities between HMO subscriber contracts and insurance policies, an HMO contract is not an "insurance policy" for purposes of the Insurance Code, and an HMO is not an "insurer" for purposes of the Insurance Code. As a result, insurance fraud laws do not apply to fraud involving an HMO, and fraud involving an HMO is not within the jurisdiction of the Division of Insurance Fraud.

B. EFFECT OF PROPOSED CHANGES:

As is described in more detail in "Section-by-Section Research," below:

Persons who commit specified acts of insurance fraud would be subject to second-degree or first-degree felony penalties, rather than being subject to the third-degree

[5] See s. 775.15(2)(e), F.S.

[6] 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.

felony penalties that currently apply. 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.

Health Maintenance Organizations (HMOs) would be required to establish anti-fraud units or anti-fraud plans, and criminal prohibitions against false and fraudulent insurance claims and applications would be expanded to include HMOs.

The jurisdiction of the Division of Insurance Fraud of the Department of Insurance would be expanded to include all criminal violations of the workers' compensation law and HMO fraud.

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 insurance fraud.

An appropriation of $250,000 from the Insurance Commissioner's Regulatory Trust Fund would be provided to fund 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 requires the Department of Insurance to adopt rules to implement and administer the Anti-Fraud Reward Program created by the bill.

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

Yes. The bill requires insurers and HMOs to file annual anti-fraud reports with the Department of Insurance.

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

No.

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?

No.

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

No.

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

No.

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

No.

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

No.

3. Personal Responsibility:

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

No.

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.

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

      No.

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:

Chapters 440, 626, 641, 775, and 817, F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1 amends s. 440.09, F.S., relating to workers' compensation insurance coverage. Currently, an employee is not entitled to benefits if an administrative hearing officer, court, or jury determines that the employee violated s. 440.15, F.S. (which provides criminal penalties for numerous acts relating to workers' compensation claims, evidence of compliance with workers' compensation requirements, premium fraud, coercion, and improper fees). This section of the bill provides that the same sanction would apply if a violation was determined by a judge of compensation claims, and changes the term "administrative hearing officer" to "administrative law judge" to conform to Chapter 96-159, Laws of Florida.

Section 2 amends s. 440.105, F.S., relating to violations of the workers' compensation law. This section of the bill increases the penalty for felony violations of s. 440.105, F.S. 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 3 amends s. 626.989, F.S., relating to the jurisdiction of the Division of Insurance Fraud. This section expands the jurisdiction of the division to include all violations of s. 440.105, F.S., which provides misdemeanor and felony penalties for various violations relating to workers' compensation premiums and claims.

This section also provides that for purposes of the jurisdiction of the division, an HMO is to be considered an insurer, and an HMO subscriber contract is to be considered an insurance policy.

Section 4 amends s. 626.9891, F.S., relating to insurer anti-fraud units and anti-fraud plans. This section would require all insurers (including insurers required to establish anti-fraud units) to file or refile anti-fraud plans by July 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, and workers' compensation insurance, and by adding a requirement that the plan specify procedures for auditing workers' compensation insureds.

The bill would require insurers to file anti-fraud reports with the department annually.

Section 5 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 criminal violations of the Insurance Code, section 440.105 (specified workers' compensation violations), or section 817.234 (false and fraudulent insurance claims and applications).

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 be required to adopt rules providing for application and evaluation procedures, procedures to assure that the granting of rewards reflects the law enforcement priorities of the Division of Insurance Fraud, criteria for determining whether the information reported to the department in fact led to an arrest and conviction, and procedures for publicizing the availability of rewards.

Neither the decision to make an award or not make an award, nor the amount of the reward itself, would be a "decision which affects substantial interests" under the Administrative Procedure Act.[7] As a result, a person would not be entitled to an administrative hearing with respect to these decisions.

Section 6 creates s. 641.3915, F.S., relating to anti-fraud units and plans of health maintenance organizations. This section would apply to health maintenance organizations (HMOs) the same anti-fraud unit and anti-fraud plan requirements as apply to insurers (see section 4, above).

Section 7 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" 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.

[7] See s. 120.569, F.S.

This section also includes HMOs within the definition of "insurer," and includes HMO subscriber contracts within the definition of "insurance policy." As a result, acts of insurance fraud involving HMOs would be subject to the same criminal penalties as acts of insurance fraud involving insurance companies.

Section 8 amends s. 775.15, F.S., relating to criminal statutes of limitations. The bill would extend the statute of limitations for felony violations of s. 440.105, F.S.,[8] or s. 817.234, F.S.,[9] to 5 years.

Section 9 appropriates $250,000 from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance to implement the reward program created by s. 626.9892, F.S.[10]

Section 10 provides that the bill will take effect upon becoming a law.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Expenditure	FY 1998-99
Ins. Comm'r's Reg. Trust Fund	($250,000)

2. Recurring Effects:

N/A

3. Long Run Effects Other Than Normal Growth:

N/A

4. Total Revenues and Expenditures:

See above.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

[8] Workers' compensation fraud; see section 2, above.

[9] False and fraudulent insurance claims and applications; see section 7, above.

[10] See section 5, above.

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 create costs of compliance with a new requirement that insurers annually file a fraud report with the Department of Insurance.

2. Direct Private Sector Benefits:

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

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

   See above.

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:

HB 3561 as filed was substantially similar to CS/HB 3561, except for the following:

The original bill included provisions allowing the Department of Insurance to impose fines and take actions with respect to insurers' rates and licenses as sanctions for the failure to devote sufficient resources to anti-fraud activities. These provisions are not included in the Committee Substitute.

The original bill granted broad rulemaking authority to the Department of Insurance with respect to anti-fraud plans and anti-fraud units.

The original bill did not include HMOs within the jurisdiction of the Division of Insurance Fraud or apply criminal prohibitions of insurance fraud to fraud involving HMOs.

VII. SIGNATURES:

COMMITTEE ON FINANCIAL SERVICES:

Prepared by:	Legislative Research Director:
Leonard Schulte	Stephen Hogge