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

BILL #: HB 3561

RELATING TO: Insurance fraud

SPONSOR(S): Reps. Goode and Crist

COMPANION BILL(S): SB 1640 (s)

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

(1) FINANCIAL SERVICES
(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.

The Department of Insurance would be able to evaluate insurers' anti-fraud units and anti-fraud plans, and could use fines against insurers, suspensions of insurers' certificates of authority, and actions with respect to insurers' rate filings as sanctions against insurers whose anti-fraud units and anti-fraud plans are not satisfactory to the department. Sanctions could be imposed against an insurer that does not allocate "sufficient resources to identify and eliminate fraud," but the term "sufficient resources" is not defined and no standards are provided for the imposition of sanctions.

Health Maintenance Organizations (HMOs) would be required to establish anti-fraud units or anti-fraud plans.

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.

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 law or from violations of the law prohibiting false and fraudulent insurance claims and applications.

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.

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.[5]

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.

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 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.

The Department of Insurance would be able to evaluate insurers' anti-fraud units and anti-fraud plans, and could use fines against insurers, suspensions of insurers' certificates of authority, and actions with respect to insurers' rate filings as sanctions against insurers whose anti-fraud units and anti-fraud plans are not satisfactory to the department. Sanctions could be imposed against an insurer that does not allocate "sufficient resources to identify and eliminate fraud," but the term "sufficient resources" is not defined and no standards are provided for the imposition of sanctions.

[5] 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 Maintenance Organizations (HMOs) would be required to establish anti-fraud units or anti-fraud plans.

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.

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 law or from violations of the law prohibiting false and fraudulent insurance claims and applications. 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 authorizes the Department of Insurance to adopt "any rules necessary" to implement provisions of the bill relating to insurer anti-fraud units and plans and HMO anti-fraud units and plans. The bill requires the department to adopt "procedures" 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?

Yes. The bill would give the Department of Insurance the authority to levy a variety of sanctions on insurers and HMOs whose anti-fraud units or plans are not satisfactory to the department. Current law requires insurers to establish anti-fraud plans or anti-fraud units and to file information regarding the plans or units with the Department of Insurance, but does not give the department the power to approve, disapprove, or modify anti-fraud units or plans.

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, 624, 626, 627, 641, 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.

This section also appears to provide an extended statute of limitations. The bill provides that "a proceeding under subsection (4)" (relating to felony violations of s. 440.105, F.S.) may be commenced within 5 years after the "cause of action accrues," and that this statute of limitations is tolled (suspended) during the pendency of a criminal prosecution for a violation of subsection (4) and for 2 years thereafter. The bill, however, does not create a civil cause of action for these violations. This statute of limitations would not

appear to affect the criminal statute of limitations as described in "Present Situation," above.

Section 3 amends s. 624.416, F.S., relating to insurers' certificates of authority. This section of the bill would provide that before the Department of Insurance approves a revision to an existing certificate of authority to allow an insurer to transact an additional line of business, the department must require the insurer to demonstrate compliance with anti-fraud unit or anti-fraud plan requirements and must require the applicant "to allocate sufficient resources to identify and eliminate fraud." The term "sufficient resources" is not defined. The department would be required to consider the extent of these resources in determining whether to allow the insurer to transact an additional line of business.

Section 4 amends s. 624.416, F.S., relating to suspension or revocation of insurers' certificates of authority. This section of the bill would allow the department to suspend or revoke an insurer's certificate of authority of an insurer that has failed to comply with anti-fraud unit or anti-fraud plan requirements or that has "failed to allocate sufficient resources to identify and eliminate fraud." The term "sufficient resources" is not defined.

This section also allows the department to impose fines for these acts, by virtue of s. 624.4211, F.S., which allows the department to impose fines of up to $20,000 per violation in lieu of suspending or revoking a certificate of authority.

Section 5 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.

Section 6 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 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, 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.

The department would be authorized to adopt "any rules necessary" to implement these requirements.

Section 7 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. All "determinations and other actions of the department" under this section 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 8 amends s. 627.062, F.S., relating to rates for property and casualty insurance (other than motor vehicle insurance or workers' compensation insurance). Current law specifies 13 factors that must be considered by the Department of Insurance in evaluating a rate filing. This section would add an additional factor: compliance with the anti-fraud plan requirements of s. 626.9891 (see section 6, above) and the allocation of sufficient resources to identify and eliminate fraud. It is not clear whether the result of applying this factor would be to increase an insurer's rates, so that it would have the "sufficient resources" called for, or would be to decrease the insurer's rates as punishment for failure to meet the requirements.

Section 9 amends s. 627.072, F.S., relating to rates for workers' compensation insurance. Current law specifies 7 factors that must be considered by the Department of Insurance in evaluating a rate filing. This section would add an additional factor: compliance with the anti-fraud plan requirements of s. 626.9891 (see section 6, above) and the allocation of sufficient resources to identify and eliminate fraud. It is not clear whether the result of applying this factor would be to increase an insurer's rates, so that it would have the "sufficient resources" called for, or would be to decrease the insurer's rates as punishment for failure to meet the requirements.

Section 10 amends s. 627.411, F.S., relating to grounds for disapproval of policy forms. One of the grounds for disapproval of a health insurance form is that the benefits are unreasonable in relation to the premiums charged; this provision gives the Department of Insurance regulatory power over health insurance rates. This section of the bill would add an additional factor: compliance with the anti-fraud plan requirements of s. 626.9891 (see section 6, above) and the allocation of sufficient resources to identify and eliminate fraud. It is not clear whether the result of applying this factor would be to increase an insurer's rates, so that it would have the "sufficient resources" called for, or would be to decrease the insurer's rates as punishment for failure to meet the requirements.

Section 11 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 6, above).

Section 12 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.

This section also appears to provide an extended statute of limitations. The bill provides that a proceeding under this section may be commenced within 5 years after the "cause of action accrues," and that this statute of limitations is tolled (suspended) during the pendency of a criminal prosecution for a violation of the section and for 2 years thereafter. The bill, however, does not create a civil cause of action for these violations. This statute of limitations would not appear to affect the criminal statute of limitations as described in "Present Situation," above.

Section 13 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 7, above). It is not clear whether implementing the "purpose" of the reward program, as distinguished from its "provisions," would involve something other than providing rewards.

Section 14 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:

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.

The bill would allow the Department of Insurance to impose sanctions (including fines and actions with respect to rate filings) on insurers for failure to comply with anti-fraud unit and anti-fraud plan requirements, and for failure to allocate sufficient resources to identify and eliminate fraud. These fines and rate actions could further reduce the resources an insurer is able to devote to identifying and eliminating fraud.

2. Direct Private Sector Benefits:

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 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:

N/A

VII. SIGNATURES:

COMMITTEE ON FINANCIAL SERVICES:

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