HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/CS/HB 1007 Insurer Anti-Fraud Efforts
SPONSOR(S): Commerce Committee; Government Operations & Technology Appropriations Subcommittee; Insurance & Banking Subcommittee; Raschein and others
TIED BILLS: CS/HB 1009 **IDEN./SIM. BILLS:** CS/SB 1012

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Peterson	Luczynski
2) Government Operations & Technology Appropriations Subcommittee	12 Y, 0 N, As CS	Helpling	Topp
3) Commerce Committee	25 Y, 0 N, As CS	Peterson	Hamon

SUMMARY ANALYSIS

Insurance fraud is a deliberate deception perpetrated against or by an insurance company or agent for the purpose of financial gain. Fraud may be committed at different points in the insurance transaction by applicants for insurance, policyholders, third-party claimants, or professionals who provide services to claimants. Insurance agents and company employees may also commit insurance fraud.

The Division of Investigative and Forensic Services (DIFS) within the Department of Financial Services (Department) encompasses all law enforcement and forensic components residing within the Department. The DIFS investigates a wide range of fraudulent and criminal acts, including insurance fraud and workers' compensation fraud.

The bill establishes uniform fraud prevention standards applicable to all insurers. The bill requires all insurers, regardless of size, to establish and maintain a fraud investigation unit, or contract for such services, and to submit an anti-fraud plan. An insurer must submit the plan and the description of the unit, together with the name of the employee designated to oversee fraud investigation activities, to the DIFS beginning December 31, 2017, and annually thereafter. The bill specifies required elements of the plan, which include: acknowledgements related to implementation of fraud detection and investigation procedures, mandatory reporting procedures, and anti-fraud education and training; descriptions of the anti-fraud unit and required education and training; and the rationale for the anti-fraud unit staffing. In addition, the bill creates a requirement for insurers to submit fraud-related data on an annual basis. The bill modifies the additional requirements applicable to workers' compensation insurers to require reporting of the number of cases referred to the DIFS.

Since 2003, insurance fraud has been prosecuted through dedicated positions within certain state attorneys' offices which are funded by state appropriation. The bill requires state attorneys' offices that receive such an appropriation to report quarterly data to the DIFS regarding their caseloads beginning September 30, 2017. The bill also requires the DIFS to report the caseload data annually to the Governor and the Legislature beginning September 1, 2018.

The bill has no impact on state or local governments and an indeterminate impact on the private sector. *See Fiscal Analysis and Economic Impact Statement*.

The bill provides for an effective date of September 1, 2017, except as otherwise expressly provided.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Insurance Fraud

Insurance fraud is a deliberate deception perpetrated against or by an insurance company or agent for the purpose of financial gain. Fraud may be committed at different points in the insurance transaction by applicants for insurance, policyholders, third-party claimants, or professionals who provide services to claimants. Insurance agents and company employees may also commit insurance fraud. Common frauds include "padding," or inflating actual claims, misrepresenting facts on an insurance application, submitting claims for injuries or damage that never occurred, and "staging" accidents.

Insurance fraud may be classified as "hard" or "soft." Hard fraud is a deliberate attempt either to stage or invent an accident, injury, theft, arson, or other type of loss that would be covered under an insurance policy. Soft fraud, which is sometimes called opportunity fraud, occurs when a policyholder or claimant exaggerates a legitimate claim. Soft fraud may also occur when people purposely provide false information to influence the underwriting process in their favor when applying for insurance.[1]

The Federal Bureau of Investigation estimates the total cost of insurance fraud, excluding health insurance fraud, at more than $40 billion per year. Thus, insurance fraud costs the average U.S. family between $400 and $700 per year in the form of increased premiums.[2]

Division of Investigative and Forensic Services

The Division of Investigative and Forensic Services (DIFS) within the Department of Financial Services (Department) encompasses all law enforcement and forensic components residing within the Department. The DIFS investigates a wide range of fraudulent and criminal acts including:

- Insurance Fraud
- Workers' Compensation Fraud
- Fire, Arson, and Explosives Investigations
- Theft/Misuse of State Funds
- Fire and Explosives Sample Analysis

The DIFS is directed by statute[3] to investigate fraudulent insurance acts,[4] violations of the Unfair Insurance Trade Practices Act, false and fraudulent insurance claims,[5] and willful violations of the Florida Insurance Code[6] and rules adopted pursuant to the code.[7] The DIFS employs sworn law enforcement officers to investigate insurance fraud. These officers may make warrantless arrests upon probable cause for criminal violations established as a result of an investigation.[8] The general laws applicable to arrests by state law enforcement officers apply to DIFS investigators.

The Bureau of Insurance Fraud within the DIFS investigates various types of insurance fraud including: personal injury protection, motor vehicle insurance, insurance application, licensee, homeowner's

[1] INSURANCE INFORMATION INSTITUTE, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited Mar. 21, 2017).
[2] FBI, *Insurance Fraud*, https://www.fbi.gov/stats-services/publications/insurance-fraud (last visited Mar. 21, 2017).
[3] s. 626.989(2), F.S.
[4] s. 626.989(1), F.S.
[5] s. 817.234, F.S.
[6] chs. 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S., constitute the "Florida Insurance Code." (s. 624.01, F.S.).
[7] s. 624.15, F.S.
[8] s. 626.989(7), F.S.

insurance, commercial insurance, disability insurance, arson, life insurance, and healthcare fraud.[9] The Bureau of Workers' Compensation Fraud within the DIFS investigates suspected criminal violations of Florida's workers' compensation laws. The Division of Workers' Compensation and the Bureau of Workers' Compensation Fraud work closely together to carry out their statutory duties. The Division of Workers' Compensation enforces administrative compliance with the workers' compensation law, pursuant to s. 440.107, F.S. The DIFS enforces the criminal provisions of the workers' compensation law, pursuant to s. 440.105, F.S.

Insurer Fraud Prevention

Florida law requires every admitted insurer to have some form of fraud prevention program in place.[10] Insurers with direct written premiums of at least $10 million in the prior year must establish and maintain "a unit or division"[11] to investigate fraudulent claims, typically referred to as a special investigative unit (SIU), or contract for SIU services. These insurers are required to file with the DIFS a detailed description of their SIU or the contract for services, whichever is applicable. Insurers with direct written premiums of less than $10 million in the prior year must adopt an anti-fraud plan, or comply with the requirements applicable to larger insurers. An anti-fraud plan must be filed with the DIFS and must include:

- 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 DIFS;
- 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.

An insurer has 18 months from the time it obtains a certificate of authority to comply with these requirements. The required documentation need only be filed one time; the law does not require that it be updated.

An insurer that writes workers' compensation coverage is subject to additional requirements.[12] A workers' compensation insurer is required to submit a report to the DIFS by August 1 of each year on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include:

- 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 referrals to the Bureau of Workers' Compensation Fraud for the prior year.
- A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.

[9] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *The Bureau of Insurance Fraud*, http://www.myfloridacfo.com/division/fraud/ (last visited Mar. 20, 2017).
[10] s. 626.9891(1) - (4), F.S.
[11] A "unit or division" may include assigning fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. s. 626.9891(5), F.S.
[12] s. 626.9891(6), F.S.

- The in-service education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.
- A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it.

Current law gives the Department or the Office of Insurance Regulation authority to impose: an administrative fine of up to $2,000 per day for failing to file an acceptable anti-fraud plan or SIU description; an administrative fine for failing to implement the provisions of the plan or SIU description; or both.[13]

Effect of the Bill on Insurer Fraud Prevention

The bill establishes uniform fraud prevention standards for all insurers, regardless of size. In effect, the bill imposes two new requirements: large insurers will be required to adopt an anti-fraud plan; and smaller insurers will be required both to adopt an anti-fraud plan and to establish and maintain an SIU, or contract for SIU services. In addition, the bill requires every insurer to designate an employee who is responsible for implementing the requirements related to fraud investigation.

All insurers must electronically file the anti-fraud plan, a detailed description of the SIU or the contract for services, whichever is applicable, and the name of the designated employee with the DIFS by December 31, 2017, and each year thereafter.

The bill revises the requirements for an anti-fraud plan to 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 acknowledgement that the insurer has established procedures for mandatory reporting of fraudulent insurance acts.
- An acknowledgement that the insurer provides the required anti-fraud education and training.
- A description of the required anti-fraud education and training. An insurer must provide 2 hours of initial training and 1 hour annually, thereafter, to the SIU or contractor for SIU services. The education and training must address detection, referrals, investigations, and reporting of suspected insurance fraud for the lines of insurance the insurer writes. The bill requires the initial 2-hour training to be completed by December 31, 2018.
- A description or chart of the insurer's SIU, including position titles and descriptions of staffing.
- The rationale for the level of staffing and resources being provided for the SIU.

In effect, the bill expands the requirements for an anti-fraud plan to include two requirements, with some modifications, that apply only to workers' compensation insurers today: the rationale for staffing levels and a description of the anti-fraud education and training. The bill also revises the standard applicable to information included in the report. Current law requires descriptions of detection and investigation procedures, mandatory reporting procedures, and plans to provide education and training. The bill requires an insurer to acknowledge implementation of these requirements. The acknowledgement operates as an affirmation of compliance with the law and may assist the Department in any necessary enforcement proceeding.

The bill revises the requirements for those portions of the anti-fraud plan that are specific to a workers' compensation insurer by: deleting provisions that are separately added and made applicable to all insurers; clarifying the requirements for reports related to losses and recoveries; and adding a requirement to report, by fraud type, the number of cases referred to the DIFS.

[13] s. 626.9891(7), F.S.

The bill creates a new requirement for all insurers to report fraud-related data for each line of insurance written in the prior calendar year. The data must be submitted by March 1, 2019, and annually thereafter, and 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 matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the DIFS;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount or range of damages on cases referred to the DIFS or other agencies.

The bill adds noncompliance with the data reporting requirement as a basis for imposing an administrative fine.

An insurer that obtains a new certificate of authority has 6 months to comply with the requirement to adopt and file an anti-fraud plan, description of its SIU or contract for SIU services, and the name of the designated employee. The insurer has one calendar year thereafter to complete the required education and initial data collection and reporting.

Dedicated Prosecutor Program

Since 2003, insurance fraud has been prosecuted through dedicated positions within certain state attorneys' offices. The first dedicated prosecutor position was jointly funded by the Department, the Miami-Dade state attorney's office and the Florida Automobile Joint Underwriting Association. As of June 30, 2016, the dedicated prosecutor program had a total of 36 full-time positions, including 20 dedicated prosecutors. Of the 20 dedicated prosecutors, one position in Miami-Dade County, one position in Tampa, one position in West Palm Beach, and one position in Broward County are devoted solely to Worker's Compensation Fraud.[14,15] In 2016, the Legislature appropriated $1,725,519 from the Insurance Regulatory Trust Fund and $614,735 from the Workers' Compensation Trust Fund to the Justice Administrative Commission[16] to fund the dedicated prosecutor positions.[17]

Current law does not specify requirements for participation in the dedicated prosecutor program. Instead, it has been authorized by proviso language in the General Appropriations Act. The 2016 proviso states that "funds may not be used for any purpose other than the funding of attorney and paralegal positions that prosecute crimes of insurance fraud." The Department indicates that, in the absence of any specific statutory requirement, participating state attorneys' offices submit voluntary, quarterly reports with general caseload data. Through analysis of the reports, the DIFS has found that certain participating state attorneys' offices are prosecuting minimal amounts of insurance fraud cases,

[14] The positions are allocated as follows: Jacksonville (4th Judicial Circuit-two), Orlando (9th Judicial Circuit-three), Miami-Dade County (11th Judicial Circuit-five), Tampa (13th Circuit-five), West Palm Beach (15th Circuit-two) Broward County (17th Circuit-two), and Ft. Myers (20th Circuit-one) along with accompanying support staff positions.
[15] Florida Department of Financial Services, Agency Analysis of 2017 House Bill 1007, p.2 (Mar. 14, 2017).
[16] The Justice Administrative Commission is comprised of two state attorneys and two public defenders. Its duties include, among others, maintenance of a central office for administrative services for state attorneys and public defenders. s. 43.16, F.S.
[17] ch. 2016-66, Laws of Fla.

prosecuting a majority of non-insurance fraud cases, or have had vacant positions for extended periods of time.[18]

Effect of the Bill on Dedicated Prosecutor Program

The bill requires state attorneys' offices that receive an appropriation to fund attorneys and paralegals dedicated solely to the prosecution of insurance fraud to report quarterly data to the DIFS regarding their caseloads beginning September 30, 2017. The data are to be reported for each attorney funded by the appropriation and grouped by case type, including DIFS insurance fraud cases, other insurance fraud cases, and cases not involving insurance fraud. The data must include:

- The number of cases in which an information has been filed;
- The number of cases pending at pretrial or intake;
- The number of cases in which the attorney is assisting in the investigation;
- The number of cases closed or disposed of during the prior quarter;
- The disposition of the cases closed during the prior quarter; and
- The number of cases currently pending in a pretrial diversion program.

These data are the same that are reported voluntarily by some of the state attorneys' offices.

In turn, the DIFS must report the data collected for the year ending June 30, to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2018, and annually thereafter.

B. SECTION DIRECTORY:

Section 1: Amends. s. 626.9891, F.S., relating to insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.
Section 2: Creates s. 626.9891, F.S., relating to dedicated insurance fraud prosecutors.
Section 3: Amends s. 641.3915, F.S., relating to health maintenance organization anti-fraud plans and investigative units.
Section 4: Provides an effective date of September 1, 2017, except as otherwise expressly provided in the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[18] Florida Department of Financial Services, Agency Analysis of 2017 House Bill 1007, p.2 (Mar. 14, 2017).

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurance companies may incur additional costs in implementing the new requirements for their fraud-prevention programs and the required data reporting. However, these costs may be more than offset if compliance results in more effective fraud prevention and enforcement.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill requires the Department to adopt rules to implement the mandatory fraud-related data reporting.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 27, 2017, the Insurance & Banking Subcommittee considered a proposed committee substitute and reported the bill favorably as a committee substitute. The committee substitute reflects multiple changes, as follows:

- Removed language amending s. 440.50, F.S., relating to the Workers' Compensation Administration Trust Fund;
- Reordered and revised the language relating to required elements and deadlines affecting insurers' anti-fraud programs to make them uniformly applicable to all insurers, regardless of size;
- Revised terminology for internal consistency;
- Created definitions of "designated anti-fraud unit or division" and "anti-fraud investigative unit"; and
- Clarified the elements of the Insurance Fraud Dedicated Prosecutor Program.

On April 17, 2017, the Government Operations & Technology Appropriations Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment removed the section related to the creation of an Insurance Fraud Dedicated Prosecutor Program within the DIFS.

On April 24, 2017, the Commerce Committee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Required the Department of Financial Services to adopt rules to administer the insurer fraud data reporting requirements;
- Required state attorneys' offices that receive an appropriation to fund attorneys and paralegals dedicated solely to the prosecution of insurance fraud to report quarterly data to the DIFS regarding their caseloads beginning September 30, 2017;

- Required the DIFS to report the caseload data annually to the Governor and the Legislature beginning September 1, 2018; and
- Revised the effective date.

The staff analysis has been updated to reflect the committee substitute.