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 Appropriations Subcommittee on General Government

BILL:	CS/SB 1012
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Insurer Anti-fraud Efforts
DATE:	April 17, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Fav/CS**
2.	Sanders	Betta	AGG	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1012 creates new requirements for insurance companies relating to insurance fraud prevention and reporting. The bill requires all insurers 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 and a copy of the anti-fraud plan. This filing must be made annually on or before December 1, starting in 2017.

The anti-fraud plan must include:

- An acknowledgment that the insurer has established procedures for detecting possible fraudulent insurance acts;
- An acknowledgement that the insurer has established procedures for reporting such acts to the DFS;
- An acknowledgement that the insurer provides required anti-fraud education to employees;
- A description of the anti-fraud education;
- A description of the insurer's anti-fraud unit; and
- The rationale for staffing levels and resources provided to the anti-fraud unit.

Beginning in 2019, the bill requires every insurer to annually submit anti-fraud statistics to the DFS by March 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 modifies reporting requirements for workers' compensation insurers.

The bill creates a dedicated prosecutor program administered by the DFS. The DFS does not anticipate an impact to any state revenues or expenditures.[1] The program will allow state attorneys to seek grants from the DFS, subject to funding by the Legislature, to add positions to prosecute insurance fraud cases.

The bill take effect on September 1, 2017.

II. Present Situation:

The Department of Financial Services (DFS) regulates insurance agents, insurance agencies, and insurance adjusters. The DFS' Division of Investigative and Forensic Services (division) contains sworn law enforcement officers 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. Florida statutes direct the division 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.[2]

[1] Email from Elizabeth Boyd, Legislative Affairs Director (April 7, 2017) (on file with the Senate Appropriations Subcommittee on General Government).
[2] http://www.fldfs.com/Division/DIFS/resources/documents/2014-15_Annual-Report.pdf (last accessed March 29, 2017).

Insurance Fraud

According to the Insurance Information Institute (III), 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.[3]

The III further states that:

> 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.[4]

According to the National Insurance Crime Bureau[5] (NCIB), questionable insurance claims rose from 100,201 in 2011 to 116,171 in 2012; which is a 16 percent increase.[6] Furthermore, fraud is the second most costly white-collar crime in America behind tax evasion.[7] According to the NICB, fraud leads to higher insurance rates, causes taxes to rise, and inflates prices for consumer goods.[8]

The Federal Bureau of Investigation estimates the total cost of insurance fraud, excluding health insurance fraud, at more than $40 billion per year. Insurance fraud costs the average U.S. family between $400 and $700 per year in the form of increased premiums.[9]

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[3] Insurance Information Institute, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited April 11, 2017).
[4] *Id*.
[5] The National Insurance Crime Bureau (NCIB) is a not-for-profit organization that receives support from nearly 1,100 property and casualty insurance companies and self-insured organizations. The NCIB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals. https://www.nicb.org/about-nicb (last visited April 11, 2017).
[6] Insurance Information Institute, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited April 11, 2017).
[7] The NICB, Insurance Fraud: Understanding the Basics, https://www.nicb.org/theft_and_fraud_awareness/fact_sheets (last visited April 12, 2017).
[8] *Id.*
[9] The Federal Bureau of Investigation, Insurance Fraud, https://www.fbi.gov/stats-services/publications/insurance-fraud (last visited April 11, 2017).

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, or provide a copy of the contract, to the division.[10]

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.[11] 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.[12]

Workers' compensation insurers are required to report the following to the DFS 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 anti-fraud unit, which may include the objective criteria such as:
  - Number of policies written;
  - Number of claims received on an annual basis;
  - Volume of suspected fraudulent claims currently being detected; and
  - An assessment of optimal caseload that can be handled by an investigator;
- 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.[13]

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, Office of Insurance Regulation (OIR), or Financial Services Commission may impose certain administrative fines.[14]

[10] Section 626.9891(1), F.S.
[11] Section 626.9891(2), F.S.
[12] Section 626.9891(3), F.S.
[13] Section 626.9891(6), F.S.
[14] Section 626.9891(7), F.S.

Dedicated Prosecutor Program

The Dedicated Prosecutor Program (program) was created in September of 2003 and the first dedicated prosecutor position was jointly funded by the DFS, the Miami-Dade State Attorney's Office, and 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 workers' compensation fraud.[15]

Current law does not specify requirements for participation in the program. Instead, the program is authorized by proviso language in the General Appropriations Act. The 2016 proviso states "funds may not be used for any purpose other than the funding of attorney and paralegal positions that prosecute crimes of insurance fraud." The DFS 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 division has found that certain participating state attorney's offices are prosecuting minimal amounts of insurance fraud cases, prosecuting a majority of non-insurance fraud cases, or have had vacant positions for extended periods of time.[16]

III. Effect of Proposed Changes:

Anti-Fraud Requirements Imposed on Insurance Companies (Section 1)

Section 1 amends s. 626.9891, F.S., to create more uniform requirements for insurers to create anti-fraud units and anti-fraud plans than those that exist in current law. This section requires every insurer to designate at least one employee responsible for meeting the requirements of s. 626.9891, F.S. As an administrative expense for ratemaking purposes, insurers must include the additional cost incurred in creating an anti-fraud unit, hiring additional employees, or the cost of contracting with another entity to fulfill the requirements of this act.

"Anti-fraud investigative unit," as used in this section, means the designated anti-fraud unit or division, or contractor authorized to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

This section requires all insurers to establish and maintain a designated anti-fraud unit or alternatively, to contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

Additionally, under this section, insurers are required to adopt an anti-fraud plan. 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;

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

- An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to the division;
- An acknowledgment that the insurer provides the required anti-fraud education and training to the anti-fraud unit;
- A description of the required anti-fraud education and training;
- A description or chart of the insurer's anti-fraud investigative unit including position titles and descriptions of staffing; and
- 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; and
  - An assessment of the optimal caseload that one investigator can handle on an annual basis.

Insurers must establish the anti-fraud units and anti-fraud plans (or enter into an appropriate contract) by December 31, 2017. Furthermore, the insurer must electronically file with the Department of Financial Services (DFS), on an annual basis, the anti-fraud plan or executed contract together with the name of the employee designated as responsible for implementing the requirements of this act.

This section requires every insurer to provide at least two hours of initial anti-fraud training to the designated anti-fraud investigative unit or contractor by December 31, 2018. Each insurer must also provide an annual one-hour refresher course that addresses detection, referral, investigation, and reporting of suspected insurance fraud for the types of insurance lines written by the insurer.

This section requires every insurer to submit anti-fraud statistics by March 1, 2019, and annually thereafter, for the lines written by that insurer for the prior 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 (division);
- 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, or other agencies.

Current law only requires statistical reporting from workers' compensation insurers. This section requires all insurers to provide reports by March 1, 2019, and annually thereafter.

This section also 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; and
- The number of cases referred to the division, delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;

This section provides that an insurer who obtains a certificate of authority has six months to establish the anti-fraud unit or enter into an appropriate contract. During the same six months, the insurer must adopt an anti-fraud plan and must designate an employee responsible for complying with s. 626.9891, F.S. The section further provides that the insurer has one calendar year thereafter, to file the anti-fraud plan with the DFS and comply with relevant reporting requirements. Administrative fines may be assessed if an insurer fails to comply with s. 626.9891, F.S.

Dedicated Prosecutor Program (Section 2)

Section 2 creates s. 626.9896, F.S., to create the Insurance Fraud Dedicated Prosecutor Program (program).

Legislative Intent

This section provides legislative intent to address the increasing problem of insurance fraud, the need to adequately investigate and prosecute insurance fraud and the need to create a program dedicated to the prosecution of insurance fraud. The Legislature recognizes the division can efficiently and effectively monitor the program, can direct and reallocate resources as insurance trends change and demand for prosecutorial resources shift between judicial circuits.

Purpose of the Program

This section creates a grant program within the DFS to fund the program. The purpose of the program is to provide grants to state attorneys' offices to fund attorney and paralegal positions for the exclusive prosecution of insurance fraud. The program will consist only of funds appropriated specifically for the program.

Grant Applications

Beginning in 2018, a state attorney's office seeking grant funds must submit an application to the division detailing the proposed number of dedicated prosecutors and paralegals requested for the prosecution of insurance fraud. Applications must be received by July 1 of each even-numbered year and shall identify funding needs for two years. Grant awards are contingent upon legislative appropriation and subject to renewal by the DFS. The division is required to compile and review

the timely submitted applications to establish its legislative budget request for the program for the upcoming two years.

Award of Grants

The section authorizes the division to award grants to state attorneys' offices using a formula adopted by rule. The rule must be based on metrics and data compiled by the division which allocate funds to the judicial circuits based on trends in insurance fraud and the performance and output measures reported to the division. A grant is subject to s. 215.971, F.S., and may only be used to fund attorney and paralegal positions that are dedicated exclusively to the prosecution of insurance fraud. The division shall establish the annual maximum grant amount based on funds appropriated to the DFS for funding the program.

Reporting

The section requires the division to track and report on the effectiveness and efficiency of each state attorney's office's use of the awarded grant funds. To help complete the report, each state attorney's office that is awarded a grant must submit performance and output information to the division. The report must be provided to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2020, and annually thereafter. The report must include, but is not limited to, the following:

- The amount of grant funds received and expended by each state attorney's office;
- A description of the purposes for which the funds were expended, including payment of salaries, expenses, and any other costs needed to support the delivery of services; and
- The results achieved from the expenditures made, including the number of complaints filed, the number of investigations initiated, the number of arrests made, the number of convictions, and the amount of restitution or fines paid as a result of the cases presented for prosecution.

Rules

The section provides that the DFS may adopt rules for the administration and implementation of the program, including procedures, forms, formulas and standards.

Other Provisions (Section 3)

Section 3 amends s. 641.3915, F.S., to make technical changes.

The effective date of the bill is September 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:

The fiscal impact is indeterminate. However, insurance companies may incur cost associated with implementing the provisions of this act. In addition, insurance companies may incur some costs compiling and providing statistical data to the Department of Financial Services (DFS).

C. Government Sector Impact:

The DFS anticipates no fiscal impact on state revenues or expenditures.[17] The DFS may experience minimal costs associated with rulemaking; however, those costs can be absorbed within existing resources.

The Justice Administrative Commission indicates the bill will have an indeterminate fiscal and policy impact, as the administrative needs of the Offices of the State Attorney, associated with the creation of the program, are not predictable at this time.[18]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

This bill creates section 626.9896 of the Florida Statutes.

[17] Email from Elizabeth Boyd, Legislative Affairs Director, Department of Financial Services (April 7, 2017) (on file with Senate Appropriations Subcommittee on General Government).
[18] Justice Administrative Commission, *Senate Bill 1012 Fiscal Analysis* (February 23, 2017) (on file with the Senate Appropriations Subcommittee on General Government).

IX. Additional Information:

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

CS by Banking and Insurance on April 3, 2017:

- Removes a provision related to the reversion of funds from the Justice Administrative Commission to the Workers' Compensation Trust Fund.
- Requires all insurers, regardless of the amount of premium written, to submit anti-fraud plans (or contracts) to the DFS. It modifies insurer reporting requirements.
- Requires a report to the Governor, President, and Speaker regarding the effectiveness of the dedicated prosecutor program.

B. Amendments:

None.