House
Legislative
Analysis
Section

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FRAUDULENT INSURANCE ACTS

House Bill 4682 as passed by the House
Second Analysis (10-18-95)

Sponsor: Rep. Eric Bush
Committee: Insurance

THE APPARENT PROBLEM:

Insurance company representatives have testified that there is a rising tide of insurance fraud in the country and they cite polls indicating that much of the public thinks it is okay to defraud insurance companies. While it is difficult to quantify the amount of insurance crime, industry representatives say it is a serious societal problem and a significant contributor to the cost of insurance. A claims expert for AAA Michigan (Triple A) has testified that the cost of fraud to motorists in the state might exceed $100 million annually. Nationally, say industry officials, property/casualty insurers spend at least $200 million on insurance crime detection and deterrence. One useful tool for fighting insurance fraud, says the insurance industry,would be legislation providing immunity from civil actions for those who provide information on suspected insurance fraud to insurance companies and law enforcement. Also valuable would be provisions in the law to better define insurance fraud and provide stiff penalties.

THE CONTENT OF THE BILL:

The bill would add a new Chapter 45 to the Insurance Code dealing with insurance fraud. It would, among other things, define a "fraudulent insurance act" and provide penalties for such acts; specify what kinds of information could be exchanged between insurance companies (and similar entities) and law enforcement and regulatory agencies and in what circumstances; and provide immunity from civil liability and criminal prosecution for activities related to investigating insurance fraud.

Fraudulent insurance act. Such acts would, generally speaking, consist of participation in false applications for insurance and false claims for benefits. A fraudulent insurance act would include, but not be limited to, acts or omissions committed by anyone who knowingly, and with an intent to injure, defraud, or deceive:

-- presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, reinsurer, broker, or an agent, any oral or written statement knowing that the statement contains false information concerning any fact material to an application for the issuance of an insurance policy.

-- prepares or assists, abets, solicits, or conspires with another to prepare or make, an oral or written statement intended to be presented to an insurer in connection with, or in support of, any application for an insurance policy, knowing that the statement contains false information material to the application.

-- presents or causes to be presented to an insurer any oral or written statement, including a computer-generated document as a part of, or in support of, a claim for payment or other benefit under an insurance policy, knowing the statement contains false information material to the claim.

-- assists, abets, solicits, or conspires with another to prepare or make any oral or written statement, including computer-generated documents, intended to be presented in connection with, or in support of, a claim for payment or other benefit under an insurance policy, knowing that the statement contains any false information material to the claim.

-- solicits or accepts new or renewal insurance risks by or for an insolvent insurer, reinsurer, or other entity regulated under the insurance laws of this state.

-- removes or attempts to remove the assets or record of assets, transactions, and affairs, or a material part of assets or records, from the home office or other place of business of the insurer, reinsurer, or other entity regulated under the laws of the state or from the place of safekeeping of the insurer, reinsurer, or other entity, or who conceals or attempts to conceal assets, records, transactions, and affairs (or material parts) from the insurance commissioner.

-- diverts, attempts to divert, or conspires to divert funds of an insurer, reinsurer, or other regulated entity, or of other persons, in connection with: (1) the transaction of insurance or reinsurance; (2) the conduct of business activities by an insurer, reinsurer, or regulated entity; or (3) the formation, acquisition, or

dissolution of an insurer, reinsurer, or other regulated entity.

-- knowingly and wilfully assists, conspires with, or urges anyone to fraudulently violate the act or who knowingly and willfully benefits from the proceeds derived from the fraud due to that assistance, conspiracy, or urging.

Penalties. A person who committed a fraudulent act as described above would be guilty of a felony punishable by imprisonment for not more than four years or a fine of not more than $50,000, or both, and would be ordered to pay restitution.

If a court found a "practitioner" or an insurer responsible for or guilty of a fraudulent insurance act, the court would have to notify the appropriate licensing authority in the state. The term "practitioner" would refer to a person licensed in the state to practice medicine and surgery, psychology, chiropractic, or law, or any other licensee of the state whose services are compensated, directly or indirectly, by insurance proceeds. The term would also apply to someone similarly licensed in other states and nations, and to the practitioner of any non-medical treatment rendered in accordance with a recognized religious method of healing.

Exchange of Information. Certain information considered important relating to any suspected insurance fraud could be released to an "authorized agency" by an insurer upon the agency's request and such information could be released to an insurer (or a designated agent of the company's) by an authorized agency upon a showing of good cause by the company or company's agent. (The term "authorized agency" would refer, generally, to national, state, or local law enforcement and prosecuting agencies, and the Insurance Bureau and Department of State. The term "insurer" refers to a property-casualty insurer, life insurer, third party administrator, self-funded plan, health insurer, health maintenance organization, or health care corporation, such as Blue Cross and Blue Shield.) This information would include, but not be limited to, the following.

-- insurance policy information relevant to an investigation, including any application for a policy;

-- policy premium payment records that are available;

-- history of previous claims by the insured;

-- information relating to the investigation of suspected insurance fraud, including statements of any person, proofs of loss, and notice of loss.

An insurer or its agents could notify an authorized agency when the company knew or reasonably believed it knew the identity of a person who it had reason to believe had committed a fraudulent insurance act or had knowledge of such an act that it reasonably believed had not been reported to an authorized agency. An insurer providing information in this way would have the right to request in writing information in the possession or control of the authorized agency relating to the same suspected fraudulent act. The authorized agency could, upon good cause shown, provide the requested information at the insurer's expense within 30 days of the request. (Also, an authorized agency provided with information by an insurer could release or provide it to any other authorized agency.)

An authorized agency, insurer, or an agent authorized to act on behalf of the company could not request or release information described above for any purpose other than for the investigation of suspected insurance fraud.

Except as otherwise provided by law, any information furnished under the bill would be privileged and would not be a public record. The evidence or information would not be subject to *subpoena duces tecum* (requiring the information to be produced) in a civil or criminal proceeding unless a court determined that the public interest and any ongoing investigation would not be jeopardized by issuing the subpoena. (The court would first have to notify an insurer, agent, and authorized agency that had an interest in the information and subsequent hearing.)

Access to Records. Except for information concerning a claim or investigation, a person with reason to question the accuracy of his or her report or information provided or collected by an insurer under the new chapter and who was not under indictment for a criminal offense under the chapter could obtain copies of all reports, records, or information by written request to the insurer.

A person could submit in writing a correction to any inaccurate information or an explanation for any information in his or her record or report. Corrections or explanations submitted by a person would be included in the file and be provided along with original information by an insurer when the information was provided in response to a request by an authorized agency, an insurer, or other organization.

Immunities. A person acting without malice would not be subject to liability for filing a report or requesting or furnishing orally or in writing other information concerning suspected or completed insurance fraud if

the reports or information were provided to or received from the Insurance Bureau; the National Association of Insurance Commissioners (NAIC); any federal, state, or governmental agency established to detect and prevent insurance fraud; as well as any other organization; and their agents, employees, or designees.

Except in a prosecution for perjury or insurance fraud, and in the absence of malice, an insurer (or an officer, employee, or agent of an insurer) or any private person who cooperates with, furnishes evidence, or provides or receives information regarding suspected insurance fraud to or from an authorized agency, the NAIC, or any organization, or who complies with an order issued by a court acting in response to a request by any of those entities to provide evidence or testimony, would not be subject to a criminal proceeding or a civil penalty with respect to any act that the person testified about or produced relevant matter about.

In the absence of malice, an insurer (or an officer, employee, or agent of an insurer) or any private person who cooperates with, furnishes evidence, or provides information regarding suspected insurance fraud to an authorized agency, the NAIC, or any organization, or who complies with an order issued by a court acting in response to a request by any of those entities to provide evidence or testimony, would not be subject to civil liability for libel, slander, or any other tort, and a civil cause of action of any nature would not exist against the person for filing a report, providing information, or otherwise cooperating with an investigation or examination of any of these entities.

An authorized agency, the NAIC, or any organization, and employees and officers of such entities, when acting without malice, would not be subject to civil liability for libel, slander, or any other tort, and a civil cause of action of any nature would not exist against the person for official activities or duties of the entity because of the publication of any report or bulletin related to the entity's official activities or duties.

The bill specifies that these provisions would not abrogate or modify in any way any common law or statutory privilege or immunity otherwise available to any person or entity.

Reporting by Auto Insurers. Auto insurance companies operating in the state would have to report known convictions of fraud to a central fraud registry that the insurance bureau would have to maintain. The registry would record only convictions of fraud and the type of fraud perpetrated. Each auto insurer could request information from the registry for underwriting or rating auto policies. The information could not be compiled by the bureau or used by an insurer for purposes of territorial rating.

MCL 500.4501 et al.

FISCAL IMPLICATIONS:

The House Fiscal Agency reports that the bill would result in no cost to state and local government and would result in an indeterminate increase in revenues from any fines assessed under the bill. The fines would go to support public libraries. (Fiscal note dated 8-14-95)

ARGUMENTS:

For:

The bill would help in the prevention, detection, and prosecution of insurance fraud. One key feature is the immunity that would be provided to those who offer or exchange information about suspected insurance fraud. Currently, fears of civil suits can inhibit the exchange of information and can even inhibit insurance company cooperation with law enforcement. The exchange of information is important because, among other reasons, insurance fraud is often committed by the same persons against a number of companies in succession. The availability of a record of suspected fraud can alert a company or law enforcement agency to the need for a more vigorous investigation of a particular suspicious claim. Industry officials say the passage of immunity legislation in California produced a substantial increase in the number of reported cases of fraud. The bill also puts into the Insurance Code a definition of "fraudulent insurance act" (rather than relying on scattered provisions in the code and other statutes) and provides new specific penalties. It also requires the notification of licensing agencies when a physician or lawyer or other professional is found guilty of insurance fraud. A more vigorous attack on insurance fraud will over the long run lower insurance costs. Consumers will be the beneficiary. There could also be a change in public attitudes about the acceptability of defrauding insurance companies. It should be noted that the substitute reported by the House Insurance Committee contains provisions advocated by critics protecting consumers from faulty information and extending the list of fraudulent acts to cover misdeeds by and within insurance companies.

Fraud is a serious problem and a significant contributor to insurance costs. Triple A, for example, has testified that as a result of a refocused and expanded anti-fraud effort, more than $3 million in fraudulent no-fault injury claims were identified and deterred. The company is stepping up its efforts in homeowner's and

casualty insurance as well. The bill, particularly its immunity provisions, will allow insurance companies in the state to become more aggressive in their fight against fraud.

Response:

Earlier versions of the bill were stronger. They contained broader definitions of what would constitute a fraudulent insurance act (such as intentionally misleading information and intentional omissions) and allowed a freer exchange of information between insurance companies and private and public fraud investigators. Insurance companies have no interest in collecting this information on its customers for reasons other than fraud; provisions guarding against misuse of such information are not necessary and, in fact, might make insurance fraud investigation more difficult than it is now, contravening the original intent of the bill. The aim of the bill is to prevent fraud against insurance companies; the provisions that address potential illegal activity within companies (such as diverting funds) should be dealt with separately and not mixed in with fraudulent applications and claims. Other sections of the code deal with insurance company practices.

Against:

Critics of this kind of approach to strengthening anti-fraud laws have made a number of complaints. They say that the bill is one-sided. The provisions are aimed primarily at consumers suspected of fraud and should also apply to fraudulent activities by insurance companies. For example, if it is to be considered fraud for a policyholder to inflate somewhat the amount of damages during a claims negotiation, then the intentionally low estimate of value provided by the insurance company should be treated in the same manner. Care needs to be taken that the legislation addresses real fraud and does not instead provide additional advantages to insurance companies in negotiating or bargaining over the payment of claims. The legislature should not turn differences of opinion over claims into crimes by claimants. There has been testimony that policyholders (and health care providers) already face serious difficulties in collecting benefits they believe are due to them under their contracts and that there is considerable litigation over claims. (This might help to explain the public's attitude towards insurance claims.) A similar bill that passed the House in the last session was more balanced.

Critics also are wary of immunity provisions that allow people to spread false information without fear of reprisal and that allow insurers and investigators to exchange and collect information about consumers without regard to its accuracy. Immunity makes sense when provided for truthful information but not for false testimony or reports. On the whole, it is healthy for companies (and others) to fear lawsuits for false prosecutions; it acts as a check on irresponsible behavior towards customers and claimants. An additional criticism of the bill is that it is redundant because insurance fraud is already a crime; numerous laws already exist that can be used to prosecute or penalize people who submit false applications for insurance or false claims for damages or benefits. (There is also recent federal law on the subject.) Insurance contracts also carry provisions voiding coverage for policyholders who have concealed information or misrepresented themselves. Further, investigative tools already exist, including an all-claims, all-company data base being developed by the insurance industry and the National Insurance Crime Bureau. New technology is being employed that will greatly assist in fraud investigations. The broad, sweeping provisions of this bill are not appropriate or needed.