

# An Overview and Outline of Minnesota's New Insurance Fraud Disclosure and Immunity Law

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## **INTRODUCTION AND BACKGROUND**

In recent years, the prevention and prosecution of fraudulent insurance claims has become a paramount concern for the insurance industry. However, efforts by insurers to stem the tide of fraudulent claims has been hindered by the uncertainties and potential liabilities which may arise from reporting suspected fraud claims to law enforcement officials or other authorities.

With respect to certain types of fraudulent claims, the Minnesota Legislature had enacted legislation designed to eliminate these uncertainties. For example, the Arson Reporting Immunity Act, enacted in 1979, governs the exchange of information between insurance companies and certain "authorized persons" charged with the criminal enforcement and prosecution of arson laws. Minn. Stat. § 299F.052, et. seq. (1979). Perhaps most significantly, the Arson Reporting Immunity Act grants immunity from any civil or criminal liability to insurance companies (and their representatives) who release information required by the statute.

Until recently, there was no corresponding statute governing the disclosure of information relating to other types of fraud claims which do not involve arson. However, under a new statute – Minn. Stat. § 60A.951, et. seq. (1994), effective August 1, 1994 – Minnesota law now not only permits, but affirmatively requires an insurer to disclose information relating to any suspected “insurance fraud,” and grants immunity for all good faith disclosures made in conformance with the act.

While the new statute should eliminate many of the uncertainties which previously plagued the reporting and prosecution of suspected fraudulent claims, it does impose some new and important duties and obligations upon insurers and their agents. For instance, the statute obligates insurers to notify a law enforcement officer or other “authorized person” of suspected insurance fraud and to disclose all relevant information in the insurer's possession. Further, insurers are now required to devise and implement an "antifraud plan," and to obtain approval of that plan from the Commissioner of Commerce or Health.

Needless to say, it is imperative that insurers, their claims handling staffs, and attorneys representing insurers become familiar with the requirements of the new law. This outline will review the new statute in detail and will comment on the duties and obligations imposed upon insurers.

## **SUMMARY OF THE NEW STATUTE**

The new statute is divided into six sections.

The first section, Minn. Stat. § 60A.951, defines certain key terms that are used throughout the remainder of the statute.

The second section, § 60A.952, consists of three important subparts. Subdivision 1 requires the disclosure of certain information when such information is requested by an "authorized person." Subdivision 2 imposes upon insurers an affirmative obligation to notify and provide an "authorized person" with all "relevant information" in the insurer's possession if an insurer has reason to believe that an "insurance fraud" has been committed. Subdivision 3 provides immunity from civil or criminal liability to insurers and their representatives who release such information in good faith and in compliance with the statute.

Section 3 of the statute, § 60A.953, pertains to enforcement, and provides that the intentional failure of an insurer to comply with the reporting and disclosure requirements is punishable as a misdemeanor.

Section 4, § 60A.954, requires insurers to develop and implement an "antifraud plan." This section further requires that written notice of the implementation of the antifraud plan shall be given to either the Commissioner of Commerce or Commissioner of Health. The Commissioner of Commerce or Commissioner of Health may then review and approve or disapprove any such plan. The appropriate Commissioner may examine any insurer's procedures to determine whether the insured is complying with its antifraud plan.

The fifth section, § 60A.955, requires insurers to include an express "fraud warning" on all claim forms.

The last section of the statute, § 60A.956, provides that the requirements pertaining to the establishment of an antifraud plan and the inclusion of a fraud warning in claim forms went into effect January 1, 1995. The remainder of the statute, including the reporting, disclosure and immunity provisions, was effective as of August 1, 1994.

## **THE STATUTE**

Set forth below is a section-by-section overview of the new statute, including comments on some of the specific requirements. The actual text of the statute is included in the appendix.

## **Section 1 – Minn. Stat. § 60A.951 – Definitions.**

The first section of the statute contains definitions of the important terms used in the statute. A thorough understanding of these definitions is essential to understanding the scope and application of the reporting and disclosure provisions.

**Authorized Person.** The statute provides that information pertaining to insurance fraud must be disclosed to an "Authorized person." The statute is very specific in its definition of "authorized person," and that term includes only the following people:

- (a) the county attorney, sheriff, or chief of police responsible for investigations in the county where the suspected insurance fraud occurred;
- (b) the superintendent of the Bureau of Criminal Apprehension;
- (c) the Commissioner of Commerce;
- (d) the Attorney General;
- (e) any duly constituted criminal investigative, department or agency of the United States.

At the request of the insurance industry, the Minnesota Attorney General's Office has agreed to take the lead as the "authorized person" to whom suspected insurance fraud should be reported. Assistant Attorney General David B. Orbuch has been designated by Attorney General Skip Humphrey to be the contact for all such insurance fraud referrals. Assistant Attorney General Orbuch has developed a simple form which is entitled "Suspected Fraud Claim Report" for use in referring suspected fraud claims to the Attorney General's Office. A copy of the Suspected Fraud Claim Report containing Mr. Orbuch's address and phone number is included in the appendix.

Mr. Orbuch has informed us that his office is currently receiving 10-15 such reports per week. Upon receipt, his office reviews the report and keeps a file copy. They then determine what law enforcement agency would be most appropriate to review the suspected fraud claim and refer the matter to that agency. Alternatively, they decide there is no reason to pursue the Suspected Fraud Claim Report and close their file at that time.

**Commissioner.** "Commissioner" means:

- (a) the Commissioner of Commerce for insurers regulated by the Commissioner of Commerce;
- (b) the Commissioner of Health for insurers regulated by the Commissioner of Health.

**Insurance Fraud.** This is, of course, an important definition, since it defines the type of conduct that will trigger an insurer's obligation to act under the statute. "Insurance fraud" occurs, according to the statute, when a person presents or causes to be presented to any insurer, or prepares with knowledge or belief that it will be so presented, a written or oral statement including a computer generated document, an electronic claim filing, or other electronic transmission, that contains materially false or misleading information or a material and misleading omission concerning:

- (a) an application for an insurance policy;
- (b) the rating of an insurance policy;
- (c) a claim for payment, reimbursement or benefits payable under an insurance policy to an insured, a beneficiary, or a third party;
- (d) premiums on an insurance policy;
- (e) payments made in accordance with the terms of an insurance policy.

**Insurer.** "Insurer" means:

- (a) insurance company;
- (b) risk retention group;
- (c) service plan corporation;
- (d) health maintenance organization;
- (e) integrated service network;
- (f) fraternal benefits society;
- (g) township mutual company;
- (h) joint self-insurance plan or multiple employer trust;
- (i) persons administering a self-insurance plan.

**Relevant Information.** The term "Relevant information" sets the parameters for the type of information which must be disclosed under the statute. This term includes, but is not limited to:

- (a) policy information, including the application for a policy;
- (b) premium payment records;
- (c) a history of previous claims made by the insured;
- (d) material relating to the investigation including statements and proofs of loss;
- (e) billing records;
- (f) any other information which an authorized person identifies and which appears reasonably related to the investigation.

As can be seen from the definitions above, the "authorized persons" to whom release of suspected "insurance fraud" information is required is limited to the

people identified as "authorized persons" in the definition. Also, the definition of "relevant information" is very broad and includes any information identified by an "authorized person" which appears reasonably related to the investigation.

## **Section 2 – Minn.Stat. § 60A.952 – Disclosure of Information.**

Section 2 of the statute is the heart of the new law, and contains the notification, disclosure and immunity provisions. To ensure compliance with the requirements of Section 2, this section must be read in conjunction with the definitions section of the statute. Defined terms are indicated by **bold** type.

### **Subd. 1 – Requests for information by an authorized person.**

Subd. 1 applies where an **insurer** receives a written request for information from an **authorized person** stating that the **authorized person** has reason to believe that a crime or civil fraud has been committed in connection with an insurance claim. Where an appropriate written request from an **authorized person** is received, the insurer must release all **relevant information**, as that term is broadly defined in the definitions section of the statute.

### **Subd. 2 – Notification by insurer required.**

This section of the statute imposes an affirmative duty upon insurers to provide notice of and disclose information relative to suspected fraudulent claims.

Specifically, this section requires that, if an **insurer** has reason to believe that an **insurance fraud** has been committed, the **insurer** shall, in writing, notify an **authorized person** and provide the **authorized person** with all **relevant information** in the **insurer's** possession.

This section also provides that an **insurer** may release **relevant information** to any person authorized to receive the information under § 72A.502, Subd. 2.

That statute is part of the Minnesota Insurance Fair Information Reporting Act. It provides as follows:

#### **72A.502 Disclosure of information; limitations and conditions Subd. 2. Prevention of fraud.**

Personal or privileged information may be disclosed without a written authorization to

another person if the information is limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or material non-disclosure in connection with an insurance transaction, and that person agrees not to disclose the information further without the individual written authorization unless the further disclosure is otherwise permitted by this section if made by an insurer, insurance agent, or insurance support organization.

Under this provision of the statute, **insurers** may release **relevant information** to entities other than **authorized persons** provided there is compliance with § 72A.502.

### **Subd. 3 – Immunity from liability.**

This section provides an immunity from any civil or criminal liability to **insurers**, agents acting on their behalf and **authorized persons** who release information, whether orally or in writing, in good faith under this statute. The immunity granted by this section should shield the insurer from liability for claims of defamation, malicious prosecution and the like.

### **Section 3 – Minn.Stat. § 60A.953 – Enforcement.**

To ensure compliance with the notification and disclosure requirements, Section 3 of the statute allows criminal sanctions to be imposed upon insurers who fail to comply.

Specifically, this section provides that the intentional failure to provide **relevant information** as required by § 60A.952, Subd. 1, or to provide notification of **insurance fraud** as required by § 60A.952, Subd. 2, is punishable as a misdemeanor.

### **Section 4 – Minn.Stat. 4 60A.954 – Insurance Antifraud Plan.**

In addition to the notification and disclosure requirements, the new statute also requires **insurers** to devise and implement an "antifraud plan." This plan must be submitted to the appropriate **commissioner**.



### **Subd. 1 – Establishment of the plan.**

The antifraud plan requirements set forth in this section apply to all insurers defined in § 60A.951, Subd. 5 except for reinsurers, self-insurers, and excess insurers.

The statute requires that those **insurers** covered by this section, shall institute, implement and maintain an antifraud plan. The antifraud plan must establish procedures to:

- (1) prevent **insurance fraud**, including:
  - (a) internal fraud involving the insurer's officers, employees or agents;
  - (b) fraud resulting from misrepresentations on applications; and
  - (c) claims fraud;
- (2) report **insurance fraud** to appropriate law enforcement authorities;
- (3) cooperate with the prosecution of insurance fraud cases.

Within 30 days after implementing a new plan or modifying an existing plan, the **insurer** must notify the **commissioner**, in writing, of the plan. The notice must include the name of the person responsible for administering the plan. Although the statute simply requires that an insurer give "notice" that a plan has been implemented, many insurers have filed their plans with the appropriate **commissioner**.

It should also be noted that the statute requires insurers to devise a plan to prevent not only fraudulent claims, but internal fraud as well. Thus the scope of the antifraud plan should not be limited to the claims department.

### **Subd. 2 – Review of the Antifraud Plan.**

The "**commissioner** may review each insurer's antifraud plan to determine whether it complies with the statute. If the **commissioner** finds it does not comply, the **commissioner** shall disapprove the plan and send notice of the disapproval with the reasons for the disapproval to the insurer.

An **insurer** whose plan has been disapproved shall submit a new plan to the **commissioner** within 60 days after the plan was disapproved.

The **commissioner** may examine an **insurer's** procedures to determine whether the insurer is complying with its antifraud plan. Thus, it is insufficient to simply establish a written plan without actually implementing it.

The **commissioner** shall withhold from public inspection any part of an **insurer's** antifraud plan for so long as the **commissioner** deems the withholding to be in the public interest. The commissioner has advised that as of this time, they are withholding the antifraud plans that have been filed with them from public inspection. They have informed us that this policy may change in the future.

#### **Section 5 – Minn.Stat. § 60A.955 – Forms to Contain Fraud Warning.**

This section requires **insurers** to include an express fraud warning on all insurance claim forms issued by an **insurer** for use in submitting a claim for payment or any other benefit. This required warning must read substantially as follows:

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

An **insurer** may comply with this section by including a warning on an addendum attached to the application or claim form.

#### **Section 6 – Minn.Stat. § 60A.956 – Effective Date.**

This section provides that the effective date for the antifraud plan provisions of section 4 and the fraud warning requirements of section 5 was January 1, 1995. The balance of the statute, including the notification, reporting and disclosure requirements, was effective as of August 1, 1994.

### **SUMMARY AND COMMENTS**

Under the new statute, insurers now have an affirmative obligation to notify an "authorized person" of all instances in which the insurer believes an "insurance fraud" has been committed. So long as such disclosures are made in good faith and in accordance with the statute, the insurer will be immune from civil and criminal liability for the release or reporting of the information.

To ensure that the immunity attaches to a particular disclosure, strict compliance with the requirements of the statute should be observed. In particular, information should be disclosed only to an appropriate "authorized person" as defined in the statute or to a person authorized to receive the information under § 72A.502, Subd. 2. Requests for information received from an authorized person and the notification provided by the insurer must be in writing. Although the statute broadly defines "insurance fraud," care should be exercised to ensure that there is an adequate and well-founded "reason to believe" that fraud has been committed, and that any resulting disclosure is made in good faith.

Insurers must also take the steps necessary to implement an appropriate antifraud plan if they have not already done so. This portion of the statute is not terribly specific, and contains little to guide insurers in formulating and adopting an antifraud plan. The statute does make clear, however, that insurers must adopt and implement specific procedures designed to prevent fraud, to report fraud when it occurs, and to cooperate with the prosecution of fraud cases. The statute also requires that the plan designate an individual responsible for administering the plan. Finally, the insurer must notify the appropriate commissioner that an antifraud plan is in place.

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## INSURANCE – DISCLOSURE OF FRAUD – IMMUNITY FROM LIABILITY

## CHAPTER 574

H.F. No. 1999

AN ACT relating to insurance; requiring disclosure of information relating to insurance fraud; granting immunity for reporting suspected insurance fraud; requiring insurers to develop antifraud plans; prescribing penalties; proposing coding for new law in Minnesota Statutes, chapter 60A.

*BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:*Section 1. 60A.951 **DEFINITIONS.**

**Subdivision 1.** **APPLICATION.** The definitions in this section apply to sections 60:951 to 60A.955.

**Subd. 2. AUTHORIZED PERSON.** “Authorized person” means the county attorney, sheriff, or chief of police responsible for investigations in the county where the suspected

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insurance fraud occurred: the superintendent of the bureau of criminal apprehension; the commissioner of commerce; the attorney general; or any duly constituted criminal investigative department or agency of the United States.

Subd. 3. **COMMISSIONER.** “Commissioner” means the commissioner of commerce for insurers regulated by the commissioner of commerce, and means the commissioner of health for insurers regulated by the commissioner of health.

Subd. 4. **INSURANCE FRAUD.** “Insurance fraud” occurs when a person presents or causes to be presented to any insurer, or prepares with knowledge or belief that it will be so presented, a written or oral statement, including a computer-generated document, an electronic claim filing, or other electronic transmission, that contains materially false or misleading information, or a material and misleading omission, concerning:

- (1) an application for the issuance of an insurance policy;
- (2) the rating of an insurance policy;
- (3) a claim for payment, reimbursement, or benefits payable under an insurance policy to an insured, a beneficiary, or a third party;
- (4) premiums on an insurance policy; or
- (5) payments made in accordance with the terms of an insurance policy.

Sub. 5. **INSURER.** “Insurer” means insurance company, risk retention group as defined in section 60E.02., service plan corporation as defined in section 62C.02, health maintenance organization as defined in section 62D.02, integrated service network as defined in section 62N.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self-insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, and personas administering a self-insurance plan as defined in section 60A.23, subdivision 8, clause (2), paragraphs (a) and (d).

Subd. 6. **RELEVANT INFORMATION.** “Relevant information” includes, but is not limited to:

- (1) pertinent insurance policy information, including the application for a policy;
- (2) policy premium payment records;
- (3) a history of previous claims made by the insured including, where the insured is a corporation, limited liability company, or partnership, a history of claims by a subsidiary or any affiliates, and a history of claims of any other business association in which individual officers or partners or their family members are known to be involved;
- (4) material relating to the investigation, including the statement of any person and the proof of loss;
- (5) billing records; and
- (6) any other information which an authorized person identifies and which appears reasonably related to the investigation.

## Sec. 2. 60A.952 **DISCLOSURE OF INFORMATION.**

Subdivision 1. **REQUEST.** After receiving a written request from an authorized person stating that the authorized person has reason to believe that a crime or civil fraud have been committed in connection with an insurance claim, payment or application, an insurer must release to the authorized person all relevant information in the insurer's possession.

Subd. 2. **NOTIFICATION BY INSURER REQUIRED.** If an insurer has reason to believe that an insurance fraud has been committed, the insurers shall, in writing, notify an authorized person and provide the authorized person with all relevant information in the insurer's possession. It is sufficient for the purpose of this subdivision if an insurer notifies and provides relevant information to one authorized person. The insurer may also release relevant information to any person authorized to receive the information under section 72A502, subdivision 2.

Subd. 3. **IMMUNITY FROM LIABILITY.** If insurers, agents acting on the insurers' behalf, or authorized persons release information in good faith under this section, whether

orally or in writing, they are immune from any liability, civil or criminal, for the release or reporting of the information.

Sec. 3. 60A.953 **ENFORCEMENT.**

The intentional failure to provide relevant information as required by section 60A.952, subdivision 1, or to provide notification of insurance fraud as required by section 60A.952, subdivision 2, is punishable as a misdemeanor.

Sec. 4. 60A.954 **INSURANCE ANTIFRAUD PLAN.**

Subdivision 1. ESTABLISHMENT. An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, self-insurers, and excess insurers. Within 30 days after instituting or modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include the name of the person responsible for administering the plan. An antifraud plan shall establish procedures to:

(1) prevent insurance fraud, including: internal fraud involving the insurer's officers, employees, or agents; fraud resulting from misrepresentation on applications for insurance; and claims fraud;

(2) report insurance fraud to appropriate law enforcement authorities; and

(3) cooperate with the prosecution of insurance fraud cases.

Subd. 2. REVIEW. The commissioner may review each insurer's antifraud plan to determine whether it complies with the requirements of this section. If the commissioner finds that an insurer's antifraud plan does not comply with the requirements of this section, the commissioner shall disapprove the plan and send a notice of disapproval, along with the reasons for disapproval, to the insurer. An insurer whose antifraud plan has been disapproved by the commissioner shall submit a new plan to the commissioner within 60 days after the plan was disapproved. The commissioner may examine an insurer's procedures to determine whether the insurer is complying with its antifraud plan. The commissioner shall withhold from public inspection any part of an insurer's antifraud plan for so long as the commissioner deems the withholding to be in the public interest.

Sec. 5. 60A.955 **FORMS TO CONTAIN FRAUD WARNING.**

All insurance claim forms issued by an insurer for use in submitting a claim for payment or a claim for any other benefit pursuant to a policy shall clearly contain a warning substantially as follows: "A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime." An insurer ay comply with this section by including the warning on an addendum attached to the application or claim form. The absence of the required warning does not constitute a defense in a prosecution for a violation of chapter 609 or any other chapter of Minnesota Statutes.

Sec. 6. **EFFECTIVE DATE.**

Sections 4 and 5 are effective January 1, 1995.

Presented to the governor May 3, 1994.

Approved May 5, 1994.

SUSPECTED FRAUD CLAIM REPORT

REPORTING CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

DESCRIPTION OF FRAUD ALLEGATIONS:

SUPPORTING EVIDENCE: (List and attach all supporting documentation)

ESTIMATED DOLLAR VALUE OF ALLEGED FRAUD:

HAS ANY PRELIMINARY INVESTIGATION BEEN DONE TO DATE: \_\_\_\_ YES \_\_\_\_ NO

If yes, please describe:

SIGN: \_\_\_\_\_

DATE: \_\_\_\_\_

SEND TO: