OA 5-29-96

IN THE SUPREME COURT OF THE STATE OF FLORIDA

HTP, LTD., ETC., ET AL.,

Petitioners,

v.

LINEAS AEREAS COSTARRICENSES, S.A., ETC., ET AL.,

Respondents.

CASE NO. 86,913

BRIEF OF THE ALLIANCE OF AMERICAN INSURERS AND LIBERTY MUTUAL INSURANCE COMPANY AS AMICI CURIAE

On Petition for Discretionary Review from the District Court of Appeal, Third District of Florida

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I. INTRODUCTION

Today, the problem of insurance fraud is a top agenda item. Prosecutors hold press conferences to herald stepped-up campaigns against health care and medical provider fraud. An insurance company in Australia reports that it gained in market share based upon an advertising campaign that boasted its anti-fraud efforts.[1] Here in Florida, the legislature continually strengthens the statutory arsenal to combat fraud in all its various pernicious forms, automobile, health care, and workers' compensation fraud. Given this current "get-tough" climate, it is extraordinary to contemplate the natural consequences of extending the Economic Loss Rule to intentional torts -- the virtual elimination of the common law cause of action for fraud. See Woodson v. Martin, 663 So.2d 1327, 1330 (Fla. 2nd DCA 1995)(Altenbernd, J. dissenting). The unification of the Academy of Florida Trial Lawyers and the Alliance of American Insurers, both of which are filing Amici Curiae briefs urging this Court to exercise restraint in extending the Economic Loss Rule, signals the enormity of this issue.

Much will be briefed to this Court concerning the true legal underpinnings of the Economic Loss Rule and the theoretical and intellectual rationale for limiting this rule to negligence and strict liability actions. It is not the intent of the Amici herein to expand upon these themes.

Instead, the purpose of this brief is to express to the Court the beliefs of the insurance industry in the serious, practical consequences that will result should the Second District Court of Appeal's decision in this case be upheld. In short, at a time when both public and private anti-fraud efforts are in the forefront, one of the most effective weapons in the arsenal is on the

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[1] Kathryn Baker and Herbert Edelhertz, Fighting the Hidden Crime: A National Agenda to Combat Insurance Fraud 21 (1992) (hereinafter referred to as "Baker and Edelhertz").

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verge of elimination.

II. THE AMICI

1. The Alliance

The Alliance of American Insurers, ("the Alliance") is a national trade association of over 250 property and casualty insurance companies that serves as the industry's voice on legislative, regulatory, and economic issues. The Alliance was organized in 1922 by joining three separate associations representing companies writing fire, auto, and casualty insurance policies. Later, the three associations were forged into one organization in 1977, when non-mutual insurers were brought into the membership. Nearly fifty groups that are members of the Alliance do business in the State of Florida.

One of the chief and most significant goals of the Alliance is the eradication of fraud in the insurance industry.

2. Liberty Mutual Insurance Company

Established in Massachusetts in 1912 and headquartered in Boston, Liberty Mutual Group is a diversified financial services company of approximately 25,000 employees nationwide. Liberty Mutual is a leading provider of workers' compensation insurance, both nationally and within Florida. Liberty Mutual opened its first Florida office in 1925 and today employs 455 full-time employees providing commercial insurance services throughout the state. The company is the seventh largest business insurer in Florida, with approximately $200 million in commercial lines premiums for 1995.

Liberty Mutual Insurance Company aggressively investigates and litigates fraud cases in the State of Florida. In the area of workers' compensation premium fraud alone, it currently has filed fourteen fraud cases in this state.

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III. INSURANCE FRAUD: THE PROBLEM

In part because of its invisible nature, insurance fraud has become one of the most pernicious and costly white-collar crimes in our society. Despite growing concern and mounting efforts to curb it, the magnitude of the problem continues to increase and at a pace far in excess of the ability to control it.

Although little adequate data exists concerning the exact magnitude of the insurance fraud crisis, there is no doubt that fraud has reached serious proportions. Speculative estimates of the costs of fraud within the three major insurance sectors (property and casualty, health, and life) suggest that it is the second largest economic crime in America, exceeded only by tax evasion.[2]

Several sophisticated research studies have attempted to assess fraud in the property/casualty industry and have determined that it is possible only to assess what fraud is detected, not the total amount of fraud that exists. In fact, accurately quantifying fraud may be compared to early attempts to ascertain the number of people driving while intoxicated. Whereas records will reflect the number of persons charged and convicted of that offense, it will never be known exactly how many people drove while intoxicated and went unapprehended.

Due to a variety and confluence of reasons[3], insurance fraud is also believed to be rapidly escalating, prompting one commentator to succinctly observe: "Fraud is rampant".[4] Official statistical data such as convictions do not indicate the extent to which this increased

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[2] Id.

[3] First, insurance fraud tends to be self-perpetuating; fraud contributes to higher premiums which, in turn, increase fraud (Florida Insurance Research Center, 1990). Second, insurance fraud tends to increase in recessions (National Underwriter, 1991). See, Baker and Edelhertz at 3 (citations omitted).

[4] Robert W. Emerson, Insurance Claims Fraud Problems and Remedies, 46 U. Miami L. Rev. 907, 913 (1992) (citations omitted).

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incidence reflects the better detection and law enforcement efforts or the actual increase in the amount of fraud committed. However, in some cases, increases have been so large that enhanced law enforcement is unlikely to account for all of the increase. For example, the number of health care providers convicted of insurance fraud increased by 234% between 1979 and 1986, as compared with a 79% increase in income tax fraud convictions.[5] The vast disparity in these two rates cannot be due to increased enforcement alone.

Statistics indicate that medical scams and staged automobile accidents have shown the greatest increases, approximately 100% and 50%, respectively, from 1986 to 1989.[6] One method of estimating increases in auto-related fraud suggests that some companies have experienced a 50% increase in the last decade.[7] Based upon existing information, it is clear that health care and automobile fraud appear to be the fastest growing areas of insurance fraud. The problem of fraud however, extends well beyond auto insurance and medical provider fraud. Similar problems exist with regard to claims for workers' compensation and disability insurance. A recent survey found that 25% of the public knows someone who chose to stay home and continue receiving insurance benefits even though that person was able to return to work.[8]

IV. THE CONSEQUENCES

Mounting public concern about the price of insurance over the last few years has prompted intensified scrutiny of the various cost components to determine what is causing costs

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[5] Baker and Edelhertz at 3. (citations omitted)

[6] Id.

[7] Id. (citations omitted).

[8] Insurance Research Council, Fighting Fraud in the Insurance Industry 1 (1992) (citations omitted) (hereinafter referred to as "Fighting Fraud").

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to rise. It is now clear that fraud is one of the most significant cost drivers.

The increased significance of the insurance fraud problem stems from the fact that the costs are now being acutely felt, not just by insurance companies, but by the general public. It is presently impossible to determine precisely how much of the insurance premium or claims dollars are attributable to fraud. Fraud by its very nature defies such quantification.

Moreover, while the economic consequences of fraud are prominent, they are not the only concerns. Insurance fraud also poses a serious threat to the moral integrity of the community as neighbors condone each others' conduct.[9] Additionally, professional and business ethics are compromised as fraudulent conduct permeates and compromises those sectors. Further, the market consequences that result from competitors' fraudulent activities are significant. Against this background of pervasiveness, and in some respects permissiveness, are the present solutions.

V. CURRENT ANTI-FRAUD EFFORTS

There has been a growing awareness of the need to address the fraud crisis. Several insurance industry service organizations have been created that specialize in anti-fraud activities. In January 1992, the industry established a new organization, the National Insurance Crime Bureau (NICB), devoted exclusively to fighting insurance crime. NICB merged the fraud-fighting investigative expertise of the Insurance Crime Prevention Institute (ICPI) with the extensive anti-auto theft knowledge of the National Auto Theft Bureau (NATB).

The total expenditures that are directly allocated to fraud deterrence by all property-

[9] Fraud is a crime that in some form is condoned and/or perpetrated by a significant percentage (approximately 25-30%) of otherwise upright, law-abiding citizens. Id.

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casualty insurers are estimated to be more than $200 million per year.[10] However, even this large number understates the true amount being spent by insurers to fight fraud. Many companies that do not have actual fraud deterrence expenditures, nonetheless allocate resources to fraud deterrence that can not be determined, because fraud control is embedded in many aspects of the operation of an insurance company without necessarily being labeled fraud deterrence. Every claims adjuster and every underwriter is indirectly part of each company's fraud control program.

Regardless of the efforts and successes achieved in preventing and detecting fraud, deterrence derived from the investigation and prosecution of fraud is invaluable. Quite possibly, the maximum deterrence flows from criminal prosecution, yet this level of action may not always be possible. Prosecutors may not be able to accept a fraud case because of the acute competition for their limited resources or their own assessments of the prosecutive quality of the case. While economic crimes specialists zealously pursue prosecution, such expertise remains rare and white collar crime prosecutorial units are few in number. In Florida, only a few circuits located in large metropolitan areas, have prosecutors experienced in insurance fraud. These geographical areas may not necessarily coincide with the highest concentration of fraudulent conduct. Prosecutors find that time constraints, budget and personnel shortages, poorly drafted fraud laws, and sentencing guidelines can create other stumbling blocks. Often, prosecutors acknowledge that they prefer the prosecution of "street crimes" to white collar crimes; they may not understand "paper" crimes, and do not have the time to learn.

The growing need to deter insurance defrauders has prompted several states to create government entities that specifically address the fraud problem. The first entity of this kind

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[10] Fighting Fraud at 2.

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originated in 1945 as the Investigations Division of the North Carolina Insurance Department. The Florida Legislature was next to take action, establishing the Division of Insurance Fraud in the Department of Insurance in 1976. Though the means of achieving their goals vary, all of the state fraud bureaus share a common purpose - the detection and deterrence of insurance fraud.

The Florida Division of Insurance Fraud is part of the Florida Department of Insurance. The division has 12 offices throughout the state. Three of these offices are designated for the Bureau of Workers' Compensation Fraud, under the auspices of the Division of Insurance Fraud.

Investigative activities are the focus of the division. The investigation process at the division includes gathering additional documentation, taking sworn testimony and conducting surveillance. When the investigation is completed, a written investigative summary report is presented to the State or United States Attorney or other appropriate prosecuting agency, such as the state-wide prosecutor or Attorney General.

Though each year finds more states joining the fight against insurance fraud, serious obstacles hinder even the most determined efforts. The obstacles cited most often by fraud bureau personnel are the difficulty in getting cases prosecuted and inadequate staff. Low priority by law enforcement and the attitude that insurance fraud is a victimless crime ranked second.[11] Lack of funding, staffing and other resources for law enforcement only exacerbates the problem.

Given the myriad of factors discussed above, and the enormous value of prosecuting fraud, it is not desirable to rely upon criminal prosecutions alone to solve the problem. For all but "hard core" criminals, the currently available civil options can have significant deterrent value. The computer software industry, which is concerned with the unauthorized appropriation

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[11] Fighting Fraud at 23.

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of intellectual property, and where any criminal remedy is highly problematic, exemplifies an industry-wide effort to utilize civil actions to promote deterrence by increasing the perceived costs of software piracy. Likewise, the insurance industry has taken upon itself to actively pursue civil remedies, chief among them, a cause of action for fraud.

In 1995, the Florida Legislature enacted Section 626.9891 (Florida Statutes) entitled Insurer Anti-Fraud Investigative Units. This statute provides in pertinent part:

> (1) Every insurer admitted to do business in this state who in the previous calendar year, at any time during that year, had $10 million or more in direct premiums written shall:
>
> > (a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or
> >
> > (b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds. An insurer subject to this subsection shall file with the Division of insurance Fraud of the department on or before July 1, 1996, a detailed description of the unit or division established pursuant to paragraph (a) or a copy of the contract and related documents required by paragraph (b).

With this legislation, the Legislature has mandated that the insurers doing business in Florida establish special investigative units or SIUS. According to the legislative history, at the time of the bill's enactment, over 100 insurers doing business in Florida, including virtually all large insurers, had established SIUS to investigate fraudulent activity. [95-340, § 6, Laws of Fla. (Fla. C.S.H.B. No. 1745)] The Legislative Committee predicted that an insurer's cost of compliance would be offset by the amount of money saved by not paying on fraudulent claims. Id. Additionally, it was anticipated that to the extent that the bill reduces the frequency of fraud, and thus the amount lost due to insurance fraud, the insurer's operating costs would be reduced

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and this reduction would be passed on to the consumer in the form of premium reductions, or the absence of increased premiums. Id.

The prime functions of SIUS include investigation, training of claims personnel, evaluation and recommendations, and awareness training. Some SIUS take over all aspects of claim settlement once a file has been referred; others serve as complements and support staff to the claims adjuster. Almost all SIUS deal with auto theft, homeowner theft, arson, and auto bodily injury claims. About half of these units handle homeowner bodily injury, commercial auto, commercial property, general liability, and workers' compensation claims, and fewer than half handle professional liability claims. SIU employees typically handle about 15 cases per month and the bulk of their time is spent on investigations, field work and handling files.[12]

There are two potential objectives for the end product of those involved in these mandatory SIUS: civil suits and/or criminal prosecution. As has been discussed, it is neither practical nor prudent to rely solely upon law enforcement and over-burdened prosecutorial agencies to root out fraud. The private sector can and must proactively investigate and pursue fraud actions. The legislature continually encourages the insurance industry to do so. Yet, there seems little point in mandating SIUS if there is no fraud cause of action to pursue when the work is completed.

VI. PREMIUM FRAUD: THE PARADIGM

In the past few years, the insurance industry has significantly increased its efforts to combat fraud in the workers' compensation system. In Florida alone, the National Council on Compensation Insurance ("NCCI") and workers' compensation insurance carriers have spent several million dollars prosecuting fraud cases. In addition to litigation, statutory changes which

[12] Fighting Fraud at 2.

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strengthen insurers' offenses against fraud in the workers' compensation system have also been accomplished. Changes have also been made in the underwriting, audit, claims, and collection procedures in the residual market to actively prevent fraud.

Most examinations of workers' compensation fraud focus on the malingering claimant. The image of the supposedly "totally disabled" worker out chopping wood or climbing a ladder to paint his house is an all too familiar one to most of us. Studies report the suspicious increase in workers' compensation claims in the last few weeks before an automobile assembly plant closes. While the problem of such fraudulent claims is significant, it is also a problem that has been dealt with effectively by the insurance industry.

Large scale premium fraud is, perhaps, the least discussed aspect of workers' compensation fraud. With workers' compensation insurance, the premium owed by an employer is calculated after a determination of the risk to be assumed by the insurer. The type of business, payroll amount, and previous safety record of the insured are all factors to be considered in calculating the premium. Unfortunately, these are also factors that are misrepresented in order to lower one's premium owed. These misrepresentations, and hence the fraud, can occur at any time during the policy period, but frequently occur at the time the application for insurance is submitted or during the audit of the insured's policy.

It is only in the past few years that insurance companies and regulators have recognized that premium fraud is a serious drain on an already troubled system. While recognition of the problem of large-scale premium fraud may have been slow, the response in recent years has been quick, determined, and effective. The first defense against premium fraud has been aggressive litigation by the industry against defrauders. This case-by-case approach has produced tangible results of sizeable monetary recoveries. These high visibility premium fraud

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cases have also educated the insurance industry and the public about the problem of premium fraud, resulting in the emergence of system-wide safeguards. While it is impossible to measure the deterrent effect of these combined efforts, it is certainly plausible that another benefit has been to discourage those who otherwise would have attempted to defraud the system.

Premium fraud is an important example because instances in which this fraud occur are incredibly costly to insurers, and concomitantly, to the consumer. Unlike other forms of fraud in which the individual amount being defrauded can be low, most premium fraud cases involve hundreds of thousands, often millions, in defrauded money.

In addition, the investigation and litigation of premium fraud is an area in which insurance companies have been very aggressive, resulting in a significant amount of litigation, almost always including a cause of action for fraud. By stripping insurers of a cause of action for fraud, several dire consequences result. First, quite obviously, the deterrent value of such litigation becomes next to nil. Without a fraud claim, many actions will be left with only contract remedies. Thus, an unscrupulous employer would have little incentive to be honest when dealing with the insurer for workers' compensation because if he/she were caught, the worst that would befall him/her is that he/she would have to pay the proper premium. It is not enough just to permit the dishonest employer to pay what he or she was required to pay in the first place. If this were the case, the employer would have everything to gain and nothing to lose. For these reasons, the impact of a decision that would virtually eliminate the common law cause of action of fraud is enormous.

Additionally, the insidious effect of this type of fraud effects the entire market place. In many highly competitive industries such as roofing, the risk of employee job-related injury is also high, resulting in high premiums for workers' compensation insurance. If the dishonest

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employer choosing to keep his premium down through fraud goes unchecked, the honest competitor down the street will find it exceedingly difficult to compete. In fact, an honest business person could confront serious financial difficulties, including ruin, due to his fraudulent competitors. The idea that those who deal honestly in business can be put out of business because of their failure to commit fraud, is not to be sanctioned. Thus, the effects of insurance fraud go beyond the mere bread and butter issues of consumers and the rising price of premiums and attack the tenets of our economic system.

Insurance companies such as Liberty Mutual are actively engaged in the current anti-fraud crusade. Liberty Mutual's current case load in Florida in the area of premium fraud alone includes fourteen pending cases and twelve cases to be filed, all of which include a cause of action for fraud. It is estimated that the amount of premium that has been defrauded from this one carrier, in this one piece of the insurance fraud problem, is in the millions of dollars. The ability of the private sector to fight fraud through civil litigation cannot be undermined. Yet, without a fraud count, both the incentive of the industry to combat fraud and the deterrent value to the defrauder, are seriously jeopardized.

VII. CONCLUSION

Society has unfortunately reached a point in which all of the available resources are needed in order to effectively combat the problem of insurance fraud. The Florida Legislature has clearly recognized this crisis and acted accordingly. It seems ironic that at this critical juncture, the common law of this state has evolved to a point where the private cause of action for fraud is on the verge of extinction. That Florida courts are poised to abolish the seven hundred year old intentional tort is particularly ironic given our State's unfortunate distinction of hosting boiler room operations and other fraudulent activities. The Economic Loss Rule must

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be limited to negligence and strict liability and not expanded to include fraud or this State will suffer a major and irrevocable set back in the fight against insurance fraud.

The equation is clear and simple. If the Economic Loss Rule is applied to fraud, there will be no cause of action for fraud without personal injury or property damage. It is difficult to imagine a fraud case that results in personal injury or property damage. Most, if not all, frauds result in purely economic loss. Clearly this equation applies to all insurance fraud cases, which involve only economic loss to insurers. Therefore, the extension of the Economic Loss Rule to fraud will end the insurance industry's ability to meaningfully fight fraud.

WHEREFORE, The Alliance of American Insurers and Liberty Mutual Insurance Company respectfully request that this Court affirm the decision of the Third District Court of Appeals that declined to apply the Economic Loss Rule to a case of fraud in the inducement and instead these Amici urge this Court to adopt the reasoning of the dissent as expressed by Judge Altenbernd in Woodson v. Martin, 663 So. 2d 1327 (Fla. 2nd DCA 1995).

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Brief of The Alliance of American Insurers and Liberty Mutual Insurance Company as Amici Curiae in support of Petitioner was furnished by U.S. Mail to Lawrence R. Metsch, Esq., Metsch & Metsch, P.A., 19 West Flagler Street, Suite 416, Miami, Florida 33130; Lester M. Bridgeman, Esq., Miller Hamilton Snider Odom, P.O. Box 46, Mobile, Alabama 36601; Carl H. Hoffman, Esq., Suite 900, 241 Sevilla Avenue, Coral Gables, FL 33134 and William J. Brown, Esq., 1114 Sun Bank Building, 777 Brickell Avenue, Miami, Florida 33131, this 12 day of April, 1996.

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