

MODEL INSURANCE FRAUD BUREAU ACT

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MODEL INSURANCE FRAUD BUREAU ACT

(Adopted September 20, 1995)

Summary of Provisions



Background

The effort to combat insurance fraud must be a partnership among consumers, the insurance industry and government. The economic impact is substantial and an effective partnership will help alleviate fraud's effect on rates charged consumers and on claims paid by insurance companies.

In the past several years, 28 states have created insurance fraud bureaus by statute to investigate suspected fraudulent activity and to bring to justice violators of existing insurance fraud laws. In some cases, these bureaus have jurisdiction over all lines of insurance; in other cases, the bureaus have jurisdiction over specific areas only, such as workers compensation or health insurance fraud.

Of the 24 states that have bureaus looking at all lines of insurance, most are placed within the state's department of insurance; however, several states decided to house the bureau elsewhere. Fraud units in South Carolina, Nevada and Pennsylvania are within the attorney general's office; Massachusetts' unit is independent of any government agency or department. Staff size usually varies with the problem in the state; in New Jersey and Florida, where insurance fraud is seen as high, bureaus have staff to meet those needs with more than 100 investigators. States where insurance fraud is not considered as much of a problem have smaller bureaus. Staff size should be commensurate to the level of insurance fraud in each state.

Purpose

This model legislation establishes an insurance fraud bureau and defines its duties. It also suggests ways to fund the operations of the bureau and prosecution efforts. While the coalition recognizes the need for fraud bureaus in those states that clearly have an insurance fraud problem, the coalition encourages states to have a framework of insurance fraud laws in place prior to establishing a fraud bureau.

RATIONALE OF THE PROVISIONS

Section 1. Purpose of Act

It is the intent of the act to aggressively confront all forms of insurance fraud within the state by establishing a Division of Insurance Fraud within the Department of Insurance.

A fraud bureau facilitates the detection of insurance fraud and reduces both the occurrence of fraud and the amount of premium dollars used to pay fraudulent claims. The coalition recommends, given the background and the responsibility of insurance regulators, that the department of insurance is the most logical place to house a fraud bureau.. However, it should be noted that several states have placed its bureau in the attorney general's office. Placement decision should be based on where it would have the greatest impact on reducing fraud.

Section 2. Definition

The section defines relevant terms such as “insurance policy” and “insurance transaction” in a way that covers all forms of fraud. The legislation offers two definitions of insurance fraud. One recommended alternative defines insurance fraud broadly to include claims and application fraud, as well as fraud committed by persons who are, or are purported to be, in the insurance industry. This definition tracks the insurance fraud definition of the coalition's Model Insurance Fraud Act. The second alternative is the existing definition of insurance fraud in a state’s insurance code.

There is evidence to indicate that a fraud bureau may not function effectively when the definition of insurance fraud is too narrow. In addition, the coalition’s broadly defined alternative protects both consumers and insurers. Therefore, it is offered for states to consider adopting even though a definition may already exist.

Section 3. Division of Insurance Fraud: duties and powers

This section defines the authority of the “division of insurance fraud.” The division or bureau would initiate and conduct investigations; respond to complaints from law enforcement, governments and the public; review fraud reports from authorized insurers; and report incidents of alleged fraud to the appropriate prosecutorial office. Information supplied to the bureau remains confidential and not subject to public inspection or any state’s freedom of information law.

State laws applicable to law enforcement officers are applied to the bureau’s investigators. The bureau has the authority to administer oaths, subpoena witnesses and compel attendance at any hearing. Investigators also have the authority to make arrests.

Fraud bureau investigators should have powers and protection similar to police and other law enforcement officials if they are to be effective crime fighters. Having police status will give investigators greater access to vital information from other law enforcement agencies. Information about investigations must remain confidential in order to protect the privacy of both the person investigated and the person furnishing the material.

Section 4. Funding

The coalition's white paper discussing alternative funding mechanisms for fraud bureaus is attached to the model.

Section 5. Notice to and cooperation with the Division of Insurance Fraud

This section requires anyone who has knowledge of fraudulent activity to notify the fraud bureau and, in cases of potential claims fraud, gives the bureau a reasonable time to investigate and respond. The bill allows the establishment of a voluntary fund to reward persons not connected with the insurance industry who provide information or evidence that leads to the arrest and conviction of any person responsible for insurance fraud.

This section prevents insurers from simply paying fraudulent claims and then passing the costs on in the form of higher premiums. Under this provision, suspected cases must be reported and insurers must cooperate with any subsequent investigation. As a further incentive, insurers are given limited protection from actions by impatient claimants because this is one established indicator of a potentially fraudulent claim. A time limit allows insurers and the fraud bureau to investigate claims adequately. Monetary incentives encourage cooperation by private citizens who suspect fraud.

Section 6. Privileges and immunity

The bill grants broad immunity to any person cooperating with, or employed by, the fraud bureau in supplying information about suspected fraudulent activity if the information is provided without malice. This protection ensures individuals, especially those employed by insurers for the purpose of investigating suspected fraud, can collect, share and present information to the fraud bureau and under the proper circumstances be protected from civil liability.

The coalition believes it is essential to have broad civil immunity to ensure that information concerning suspected insurance fraud is given to the bureau, and to ensure the fullest cooperation from the insurance industry. Civil immunity will alleviate fear of lawsuits for proper transferring of information on suspected insurance fraud, which has had a chilling effect in many cases. Also, many frauds, especially organized rings, are uncovered only when insurers discover the same claims are filed with multiple insurers, or the same names or addresses appear in many claims. This provision allows insurers to share information among themselves as long as the information is used solely for the detection, prevention and prosecution of fraud.

Section 7. Refusal to cooperate with an investigation

This section would make it unlawful for anyone to resist an arrest authorized by this law or interfere with any investigation of this law.

Section 8. Other law enforcement authority

The law would not pre-empt any other law enforcement authority of the state to investigate and prosecute alleged violations of the law.

The coalition doesn't wish to discourage any other agency from investigating fraud.

MODEL INSURANCE FRAUD BUREAU ACT
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**COALITION
AGAINST
INSURANCE
FRAUD**

Model Language

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Section 1. Purpose of Act

The purpose of this Act is to confront aggressively the problem of insurance fraud in the State of _____ by facilitating the detection of insurance fraud, reducing the occurrence of such fraud through administrative enforcement and deterrence, and reducing the amount of premium dollars used to pay for fraudulent claims. This Act establishes a Division of Insurance Fraud within the Department of Insurance.

Section 2. Definitions

Actual Malice. “Actual Malice” means knowledge that information is false, or Reckless disregard of whether it is false.

Conceal. “Conceal” means to take affirmative action to prevent others from discovering information. Mere failure to disclose information does not constitute concealment. Action by the holder of a legal privilege, or one who has a reasonable belief that a privilege exists, to prevent discovery of privileged information does not constitute concealment.

Insurance fraud. “Insurance fraud” is an act committed or attempted by any Person who, knowingly and with intent to defraud, and for the purpose of depriving another of property or for pecuniary gain, commits participates in, or aids, abets, or conspires to commit or solicits another Person to commit, or permits its employees or its agents to commit any of the following acts:

- (a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or Premium Finance Company, in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact concerning any of the following:
- (1) The application for, rating of, or renewal of, any Insurance Policy;
 - (2) A claim for payment or benefit pursuant to any Insurance Policy;
 - (3) Payments made in accordance with the terms of any Insurance Policy;
 - (4) The application used in any Premium Finance Transaction;

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- (b) Presents, causes to be presented, or prepares with the knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:
- (1) The solicitation for sale of any Insurance Policy or purported Insurance Policy;
 - (2) An application for certificate of authority;
 - (3) The financial condition of any Insurer;
 - (4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;
- (c) Solicits or accepts new or renewal insurance risks by or for an insolvent Insurer.
- (d) Removes the assets or record of assets, transactions and affairs or such material part thereof, from the home office or other place of business of the Insurer, or from the place of safekeeping of the Insurer, or destroys or sequesters the same from the Department of Insurance.
- (e) Diverts, misappropriates, converts or embezzles funds of an Insurer, an insured, claimant or applicant for insurance in connection with:
- (1) An Insurance Transaction;
 - (2) The conduct of business activities by an Insurer or Insurance Professional;
 - (3) The acquisition, formation, merger, affiliation or dissolution of any Insurer.

OR IN THE ALTERNATIVE:

- C. Insurance Fraud shall have the meaning as defined by the Insurance Code Section () and by any other applicable State Law affecting fraud.

Insurance Policy. “Insurance Policy” or “policy” means the written instrument in which are set forth the terms of any certificate of insurance, binder of coverage or contract of insurance (including a certificate, binder or contract issued by a state-assigned risk plan); benefit plan; nonprofit hospital service plan; motor club service plan; or surety bond, cash bond or any other alternative to insurance authorized by a state’s financial responsibility act.

Insurance Professional. “Insurance Professional” means sales agents, managing general agents, brokers, producers, adjusters and third party administrators.

Insurance Transaction. “Insurance Transaction” means a transaction by, between or among: (1) an Insurer or a Person who acts on behalf of an Insurer; and (2) an insured, claimant, applicant for insurance, public adjuster, Insurance Professional, Practitioner, or any Person who acts on behalf of any of the foregoing for the purpose of obtaining insurance or reinsurance, calculating insurance premiums, submitting a claim, negotiating or adjusting a claim, or otherwise obtaining insurance, self-insurance, or reinsurance or obtaining the benefits thereof or therefrom.

Insurer. “Insurer” means any Person purporting to engage in the business of insurance or authorized to do business in the state or subject to regulation by the state, who undertakes to indemnify another against loss, damage or liability arising from a contingent or unknown event. “Insurer” includes, but is not limited to, an

insurance company; self-insurer; reinsurer; reciprocal exchange; interinsurer; risk retention group; Lloyd's insurer; fraternal benefit society; surety; medical service, dental, optometric or any other similar health service plan; and any other legal entity engaged or purportedly engaged in the business of insurance, including any Person or entity which falls within the definition of "Insurer" found within the _____ Insurance Code § _____.

Person. "Person" means a natural person, company, corporation, unincorporated association, partnership, professional corporation, and any other entity.

Practitioner. "Practitioner" means a licensee of this state authorized to practice medicine and surgery, psychology, chiropractic or law or any other licensee of the state or Person required to be licensed in the state whose services are compensated either in whole or in part, directly or indirectly, by insurance proceeds, including but not limited to automotive repair shops, building contractors and insurance adjusters, or a licensee similarly licensed in other states and nations or the licensed practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

Premium Finance Company. "Premium Finance Company" means a Person engaged or purported to engage in the business of advancing money, directly or indirectly, to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, including but not limited to loan contracts, notes, agreements or obligations, wherein the insured has assigned the unearned premiums, accrued dividends, or loss payments as security for such advancement in payment of premiums on Insurance Policies only, and does not include the financing of insurance premiums purchased in connection with the financing of goods and services.

Premium Finance Transaction. "Premium Finance Transaction" means a transaction by, between or among an insured, an agent or producer or other party claiming to act on behalf of an insured and a third-party Premium Finance Company, for the purposes of purportedly or actually advancing money directly or indirectly to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, wherein the insured has assigned the unearned premiums, accrued dividends or loan payments as security for such advancement in payment of premiums on Insurance Policies only, and does not include the financing of insurance premiums purchased in connection with the financing of goods and services.

Withhold. "Withhold" means to fail to disclose facts or information which any law (other than this act) requires to be disclosed. Mere failure to disclose information does not constitute "withholding" if the one failing to disclose reasonably believes that there is no duty to disclose.

Section 3. Division of Insurance Fraud: duties and powers

A. There is created within the Department of Insurance a Division of Insurance Fraud.

Drafting Note: Several states that have established insurance fraud units have placed them outside of the department of insurance. In Massachusetts, an independent fraud bureau was established and funded by the insurers in the state. South Carolina, Pennsylvania and Nevada have established fraud bureaus that were placed within the state offices of attorney general.

B. It shall be the duty of the Division of Insurance Fraud:

- 1) To initiate inquiries and conduct investigations when the Division has reason to believe that Insurance Fraud may have been or is being committed.

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- 2) To respond to notifications or complaints of suspected Insurance Fraud generated by state and local police, other law enforcement authorities, governmental units, including the federal government, and any other Person.
 - 3) To review notices and reports of Insurance Fraud submitted by authorized Insurers, their employees, and agents or producers, and to select those incidents of alleged fraud as, in its judgment, require further investigation and undertake such investigation.
 - 4) To conduct independent examination of Insurance Fraud, conduct studies to determine the extent of Insurance Fraud, deceit, or intentional misrepresentation of any kind in the insurance process, and publish information and reports on such examinations or studies.
 - 5) To report incidents of alleged Insurance Fraud disclosed by its investigations to appropriate prosecutorial authority, including but not limited to the Attorney General and to any other appropriate law enforcement, administrative, regulatory or licensing agency, and to assemble evidence, prepare charges, and otherwise assist any prosecutorial authority having jurisdiction.
- C. The Division of Insurance Fraud is authorized to employ investigators. The general laws applicable to law enforcement officers of this state shall be applicable to such investigators. The powers of the Division shall include but shall not be limited to the following:
- 1) To administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records that the Division deems relevant or material to an inquiry concerning Insurance Fraud.
 - 2) To make arrests for criminal violations established as a result of their investigations.
 - 3) To execute arrest and search warrants for the same criminal violations.
- D. Evidence, documentation, and related materials.
- 1) If the Division seeks evidence, documentation, and related materials pertinent to an investigation, and the matter is located outside of this State, the Division may designate representatives, including officials of the state where the matter is located, to secure the matter or inspect the matter on its behalf.
- E. Confidentiality and immunity from subpoena.
- 1) Papers, records, documents, reports, materials or other evidence relative to the subject of an Insurance Fraud investigation shall remain confidential and shall not be subject to public inspection or disclosure unless and until such subject is prosecuted for Insurance Fraud pursuant to such investigation.
 - 2) Papers, records, documents, reports, materials or other evidence containing individually identifiable information relating to an Insurance Fraud investigation collected or prepared by the Division of Insurance Fraud in anticipation of any civil or criminal proceeding shall be privileged, and shall not be subject to subpoena, discovery, or disclosure in any other civil action until such civil or criminal proceeding has been concluded.
 - 3) Investigators employed by the Division of Insurance Fraud shall not be subject to subpoena in civil actions by any court in this state to testify concerning any matter of which they have knowledge pursuant to a pending or continuing Insurance Fraud investigation being conduct-

ed by the Division.

- 4) This section in no way abrogates or modifies statutory or common law privileges applicable to information gathered by the Division of Insurance Fraud under this Act nor does it authorize the Division of Insurance Fraud to make public insurance company records which are proprietary in nature.

F. The Division of Insurance Fraud shall maintain records and information in order to produce an annual report of its activities as may be prescribed by the Commissioner of Insurance.

Section 4. Funding

Drafting Note: The Coalition Against Insurance Fraud has identified several options for states to consider to fund insurance fraud bureaus. A white paper discussing those options is attached.

Section 5. Notice to and cooperation with the Division of Insurance Fraud

A. Notice to the Division of Insurance Fraud.

- 1) Any Insurer or Insurance Professional that has reasonable belief that an act of Insurance Fraud will be, is being, or has been committed shall furnish and disclose the knowledge and information to the Division of Insurance Fraud, and cooperate fully with any investigation conducted by the Division of Insurance Fraud.
- 2) Any Person that has a reasonable belief that an act of Insurance Fraud will be, is being, or has been committed; or any Person who collects, reviews or analyzes information concerning insurance fraud may furnish and disclose any information in its possession concerning such act to the Division of Insurance Fraud or to an authorized representative of an Insurer that requests the information for the purpose of detecting, prosecuting or preventing Insurance Fraud.
- 3) If an Insurer has a reasonable or probable cause to believe that an Insurance Fraud has been committed in connection with an insurance claim, and has properly notified the Division of Insurance Fraud of its suspicions, such notification shall toll any applicable time period in any unfair claims practices statute or related regulation, or any action on the claim against the Insurer to whom such claim has been presented for bad faith, until thirty days after determination by the Division of Insurance Fraud and notice to the Insurer that the Division will not recommend action on the claim.
- 4) The Division of Insurance Fraud, in cooperation with authorized Insurers and Insurance Professionals may establish a voluntary fund to reward persons not connected with the insurance industry who provide information or furnish evidence leading to the arrest and conviction of persons responsible for Insurance Fraud.

Section 6. Privileges and immunities of persons cooperating with or employed by the Division of Insurance Fraud

A. No Person furnishing or disclosing to, or requesting information from the Division of Insurance Fraud or complying with an order issued by a court of competent jurisdiction to provide evidence or testimony regarding an act of suspected Insurance Fraud shall be subject to civil liability for libel, slander

or any other cause of action arising from the furnishing, disclosing or requesting of such information unless the Person furnishing, disclosing or requesting such information acts in Actual Malice, commits perjury or commits Insurance Fraud as previously defined herein.

- B. No Person employed by or authorized by an Insurer whose activities includes the investigation of or reporting of suspected Insurance Fraud who furnishes, discloses or requests information regarding an act of suspected Insurance Fraud to Persons employed by other Insurers or Insurer organizations acting in the same capacity shall be subject to civil liability for libel, slander or any other cause of action arising from the furnishing, disclosing or requesting of such information unless the Person furnishing, disclosing or requesting such information acts in Actual Malice, commits perjury or commits Insurance Fraud as previously defined herein.
- C. No employee or agent of the Division of Insurance Fraud furnishing or disclosing to or requesting information from any Person regarding an act of suspected Insurance Fraud or by publication of any report or bulletin related to the official activities or duties of the Division of Insurance Fraud, subject to the Confidentiality provision of Section 3(E) of this Act, shall be subject to civil liability for libel, slander or any other cause of action arising from the furnishing, disclosing or requesting of such information unless the Person furnishing, disclosing or requesting such information acts in Actual Malice, commits perjury or commits Insurance Fraud as previously defined herein.
- D. Any Person against whom any action is brought who is found to be immune from liability under this Section, shall be entitled to recover reasonable attorney's fees and costs from the Person or party who brought the action. This section does not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any Person.

Section 7. Refusal to cooperate with an investigation

It is unlawful under the Criminal Code Section _____ for any Person to knowingly or intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

Section 8. Other law enforcement authority

Nothing in this Act shall:

- A. Pre-empt the authority of or relieve the duty of any other law enforcement agencies to investigate and prosecute alleged violations of law.
- B. Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency other than the Division of Insurance Fraud.
- C. Limit any of the powers granted elsewhere by the laws of this State to the Commissioner of Insurance or to the Department of Insurance to investigate alleged violations of law and to take appropriate action.

MODEL INSURANCE FRAUD BUREAU ACT

Discussion Paper

Fraud Bureau Funding

Background

During research on model fraud bureau legislation, the Coalition Against Insurance Fraud identified six potential funding sources for the operation of an insurance fraud bureau.

It is the coalition's view that government has an important role to play in the ongoing fight against insurance fraud. The effort must be a joint partnership of consumers, the insurance industry and government in order to have a real impact on reducing the cost of fraud on premiums consumers and businesses pay, and on the claims costs borne by insurers.

Insurance fraud bureaus are a means to facilitate the detection of insurance fraud and the prosecution of those persons committing insurance fraud. There are currently 28 states that in recent years created insurance fraud bureaus with the sole purpose to investigate suspected fraudulent activity and to bring to justice those individuals who violate existing insurance fraud laws. In some cases, these bureaus have jurisdiction over all areas of insurance, in other cases, the bureaus have jurisdiction over only specific lines, such as health insurance or workers compensation fraud.

States vary in degree in the size of the bureau and how the bureau is funded. Some states use general revenues as a means to finance the bureau; others assess insurers and agents in the state. This white paper discusses various options the coalition has identified to fund fraud bureaus.

Funding Options

1) *General Revenues* — Several states including New York, Georgia, Alaska, and Texas utilize general revenues for the funding of the fraud bureau.

The advantage of this funding mechanism is that the resources comes out of the state budget. The funding is part of the annual state budget process and becomes part of the debate on how best to allocate state resources. One argument for including bureau funding in the general state budget is that fraud fighting benefits the general public, and thus, should be paid for by all taxpayers.

The disadvantage of general revenue funding is that the fraud bureau budget becomes part of annual budget battles. State constitutions generally mandate the state's budget be balanced, so programs may be reduced to meet that requirement. With increased pressure to lower state revenues, state budgets will be reduced in order to keep them balanced. A program such as a fraud bureau, may be viewed as an item that could be funded through other resources, such as the insurance industry, and thus would be a logical place to cut spending — possibly by eliminating the program entirely. The coalition has been told by at least one fraud bureau chief that if his state approves a major tax cut and spending reductions, the bureau would be one of the first casualties.

2) *Industry Assessments* — Arizona, California, Delaware, Massachusetts, New Jersey and Maryland fund fraud bureaus through special assessments on the insurance companies and agents licensed in the state.

The advantage is that the fraud bureau's operation isn't held hostage to the vagaries of the state budget

process. One proposal has uniform annual assessments; thus, the industry knows exactly how much each individual company pays. In several states, the assessment each company pays is less than \$500 per year, an amount that is usually deemed to be a good investment in fighting fraud. New Jersey is among several states that assesses each insurance company based on a formula on the level of business written in the state — the larger companies in this system pay a higher proportion for the operation of the fraud unit. Some states also allow insurers to pass the assessment back to the policyholder, but given the relatively inexpensive charge, most policyholders don't see an increase in their premiums. The fraud bureau also knows exactly how large a budget it will have. Maryland, for example, will set the bureau's budget and then calculate the annual assessment based on that budget total.

Disadvantages include:

- The industry already is assessed to help pay for the cost of the regulatory activities of the state insurance department. An additional assessment is one more “user fee” the industry must pay in order to do business in the state.
- Some fraud bureaus have authority to investigate both claims fraud and insurer fraud, but spend most of their time investigating insurer fraud. Thus, industry is paying the bureau to investigate itself and doesn't see action reducing the effect of claims fraud on the consumer or the industry.
- Some fraud bureaus are small and conduct relatively few investigations each year. In this instance, it is questionable whether the industry assessment supports an agency that's working in the best interest of the industry and the consumer.

3) *Per Policy Assessments* — There is currently no bureau that receives its total funding through policy assessment. However, California collects \$1 per policy to fund auto theft and fraud programs.

A major advantage to this funding scheme is that it brings the consumer directly into the effort to fight insurance fraud. Each policyholder sees an additional line on the premium payment notice for the amount that will go directly to pay for the operation of the fraud bureau. Each insurance company would collect the assessment and pass to the bureau its share based on its policyholders in the state. Consumers will see clearly there is an effort to fight insurance fraud in their state. The cost would probably be from 25 cents to \$1 per year per policy. Most states would receive more than adequate funding through this source and may even receive more than necessary.

One potential disadvantage is that skeptical consumers may see this payment as just more money going to their insurance company without receiving any immediate tangible benefit in the way of reduced premiums resulting from fighting fraud.

Insurers would bear additional costs, as well. They would have to collect the funds, segregate them from other sources of income derived from the premium and then send the funds to the state, whether in a single payment or by installments. Either way, it would increase administrative costs.

4) *Administrative or Civil Fines* — South Carolina instituted its fraud bureau in 1994 planning to fund it partially by administrative fines.

In the perfect world, this funding mechanism may be the fairest of them all. It sets up a system where people committing fraud end up paying for the operation of the bureau. With administrative remedies, there is no limit to the amount of fines the bureau can levy and how much the bureau may collect. New York col-

lected in excess of \$2 million in the first six months it levied administrative fines. New Jersey also collects more than enough to operate its bureau if it used the fines as a revenue source.

The disadvantages, however, may outweigh the advantages. South Carolina may not collect any funds for some time, since there will be lag time between investigating cases and levying the fine and then collecting it. The question begs to be asked — if the bureau goes after everyone the bureau deems has committed insurance fraud, do they all have the means to pay the fines? If not, what happens then to those who commit fraud? Levying a fine and collecting it are two distinct steps; the levying of a fine does not guarantee collection. The bureau would be operating on the faith that at some point, the fines that are levied will be collected.

Also, in a federal lawsuit against the New Jersey fraud bureau contesting administrative fines, a legal question has been raised about the constitutionality of a regulatory body that receives part of its funding from the industry it regulates to levy a fine without a judicial decision against persons accused of defrauding that industry. Whether the suit will have any effect on New Jersey's ability to levy and collect fines remains to be seen. But, if the court rules against New Jersey, this action may be taken against other states that uses similar means, and those states that rely on the fines to operate a fraud bureau would scramble to fund its operation.

Another aspect of the law suit is whether administrative fines could lead to a potential for abuse by law enforcement.

Other states have different budgetary restrictions. Some states have a prohibition against dedicated funds, so collected fines may have to be sent to the general fund of the state. It may not be possible for the fraud bureau to receive all funds collected from the state.

5) *Recovery of Legal and Investigative Expenses* — No jurisdiction uses this funding mechanism.

The advantage is similar to administrative fines: funding for the bureau's operation comes from those it has investigated and found in violation of law. Investigative costs and legal expenses could be substantial, so recovery of those expenses could potentially fund the bureau for the year. It frees the bureau from the vagaries of the state budget process since funding would be direct. Also, the bureau would not be seeking funding from consumers or the industry to help finance the bureau, easing any financial burden on either party.

The disadvantages are several. In most cases, the fraud bureau asks state prosecutors (whether district attorneys, states attorneys or the attorney general) to prosecute individuals for insurance fraud. There will be legal expenses, but by and large they will not be the bureau's expenses. Also, as with administrative fines, it is possible the individual may not have adequate resources to pay restitution, a civil fine and legal/investigative expenses.

In some instances, the fraud bureau will investigate reports of insurance fraud and decide not to recommend prosecution, and thus would not receive revenue from such cases. Similar to civil fines, there may be a time lag in collection of investigative expenses that forces the bureau to seek bridge funding until fees can be collected. If that's the case, bridge funding would be needed, and if recovery of investigative expenses is considered part of a funding mechanism, the amount recovered would be unknown and unpredictable.

6) *Percent of Criminal Fines* — There are currently no states using criminal penalties to fund the fraud bureau.

Similar to funding mechanisms that avoid the state budget process, this option keeps the bureau free from the vagaries of the special interest involvement in developing state budgets. Also, if persons convicted of fraud pay for the operation of the bureau, it avoids involvement of the victims of insurance fraud—the consumer and insurance industry. The fines would be collected as part of the criminal process through a court adjudication. Fines would be collected as all criminal fines are collected, and a portion sent to the fraud bureau for its funding.

The disadvantages also are similar to those raised with civil fines or recovery of investigative expenses. Levying a fine doesn't guarantee it will be paid, or paid in a timely manner. In most cases, people fined either may not have the funds to pay or they are able to delay payment for some time after adjudication. The fraud bureau basically has to operate on the belief that at some time, it will receive funding. At no time would the bureau be able to estimate how much money it would receive. Also, state laws may mandate all criminal fines to go to general revenues. Finally, fraud bureaus do not recommend criminal prosecution in all cases, and the prosecutor may not seek a criminal action in cases referred. Thus, the universe of possible receipts for the bureau decreases greatly.

Conclusion

The six funding options are divided evenly between victims of the fraud—the consumer and insurance industry—paying directly or indirectly for the operation of the fraud bureau, and collecting from people who commit the fraud.

The first three funding options clearly fall on the shoulders of taxpayer, policyholders and insurance industry. Whether through general revenues or through assessments, consumers and the industry end up funding the bureau. The last three options force the person who has committed the fraud to pay for the operation of the bureau.

The problem with the latter group of options is that level of funding is unpredictable. At no time during the budget process could the fraud bureau assume exactly what monies would be received, whether through administrative fines, criminal fines or for the payment of investigative expenses. The bureau would expend funds without the knowledge of how much would be returned by the end of the fiscal year.

The state would have to determine how bureau funding could be dedicated and assured of continuation without the source(s) disappearing or being transferred to other programs.

It is possible that states could combine two or more funding options. If administrative fines are used, a system similar to South Carolina may be utilized, where a base budget is set and an assessment or general revenues are used to offset any shortfalls.

In any case, there are several options for states to consider as funding mechanisms. The coalition believes each state should look at its own resources and structure to best determine the funding for its own fraud bureau. Further, states need to work with the insurance industry and consumers to ensure full support for an effective and successful fraud bureau.

MODEL INSURANCE FRAUD BUREAU ACT

Discussion Paper

Civil Fining Authority

Background

The Coalition Against Insurance Fraud believes that government has an important role to play in the ongoing fight against insurance fraud. The effort should be a partnership of consumers, the insurance industry and government in order to have a real impact on reducing the cost of fraud on premiums consumers pay and on the claims cost borne by the insurance industry.

Establishing insurance fraud bureaus can be an effective way to detect and prevent fraud. Twenty-eight states have enacted legislation to create fraud bureaus to investigate suspected fraudulent activity and to bring to justice those who violate the law. In many states, the bureaus have jurisdiction over all areas of insurance; in other states, the bureaus have jurisdiction over only specific lines, such as workers compensation or health insurance fraud.

States vary in the enforcement and prosecution of insurance fraud. Most states with fraud units give its bureau authority to bring cases to prosecutors. A handful of states including New Jersey, New York and most recently Delaware and South Carolina give their fraud bureaus authority to levy civil fines against individuals accused of committing insurance fraud. The states vary in the amount of the fines and under what circumstances these fines are levied.

New Jersey — New Jersey imposes up to \$5,000 fine for the first offense, \$10,000 fine for the second offense and \$15,000 for the third or any subsequent offenses. The fines are used to offset the debt of the state's former assigned risk pool.

New York — New York instituted civil/administrative fines in 1994. The fines collected are sent to the general revenues for the state, and the fraud bureau collected in excess of \$6 million in the first year of enforcement. The state fine is \$5,000 in addition to the value of the claim.

Delaware — Delaware's law went into effect at the end of July 1994. The bureau has collected fines through consent agreements, but has yet to assess or collect any fines through the administrative hearing process. The fraud bureau is funded through industry assessments during a three-year pilot program. Any fines collected will accrue in a separate account to fund the bureau after the third year. The administrative fine is \$10,000 for each offense.

South Carolina — The South Carolina fraud bureau, which became effective in mid-1994, uses civil penalties to help fund the bureau's operation. The bureau, which has been placed in the attorney general's office, is funded by the fines collected and through a transfer from the state insurance department. Similar to the New Jersey system, South Carolina allows for a \$5,000 fine for the first offense; up to \$10,000 for the second offense; and \$15,000 for the third and subsequent offense.

Funding Options

There appears to be several options for the use of civil fines.

1) *Funding Mechanism for Fraud Bureau* — This funding mechanism establishes a system where people

suspected of committing fraud pay for the operation of the bureau. With administrative remedies, there's no limit to the amount of fines the bureau can levy and how much the bureau may collect. New York and New Jersey impose fines in excess of \$5 million each.

In an era of tight budgets, with governments seeking tax reductions and spending limits, fraud bureaus can be viewed as a primary source of budgetary relief. Some governments and interest groups may feel the cost of an insurance fraud bureau is too high and comes at the expense of other, more "worthy," programs. State officials often view insurance fraud as a problem for industry to resolve. Using civil fines to operate the fraud bureau could help offset this attitude, especially if the amount of the fines collected exceeds the bureau's budget.

The disadvantages of utilizing civil fines for the operation of the fraud bureau include:

- South Carolina may not see any funds collected for some time, since there will be a lag between levying a fine and its collection. Delaware's bureau has been operational for months, yet no administrative fines have been imposed or collected. There's no estimate when Delaware or South Carolina will begin to see any funds collected; in any case the total is unpredictable. Even if fines are collected and used as a funding source, legislators may become tempted to use the funds to help balance tight budgets without raising taxes or cutting spending. Legislation transferring fines to the state's general fund would restrict the amount of money available to the fraud bureau.

- The ability to impose a civil fine may discourage fraud bureaus from seeking criminal prosecution. Civil fines may not deter some frauds, especially larger, sophisticated operators.

- A federal lawsuit currently pending against the New Jersey fraud bureau represents another potential drawback to civil fines. The suit raises a constitutional question whether a regulatory body that receives part of its funding from the regulated industry can levy a fine against persons accused of defrauding that industry in the absence of a judicial decision. If the court rules against New Jersey, action may be taken against other states that use similar means, and thus potentially curtailing the use of civil fines and the funding of fraud bureaus.

- Some states prohibit dedicated funds. In those cases, it may not be possible for the fraud bureau to receive funds collected from the state. However, one solution is to create an authority within the insurance department to receive the fines and to expend them for the proper purposes.

2) *Funds Used for the Bureau, Education of the Public and for the Prosecution of Insurance Fraud* — With violent crime taking up substantial amount of prosecutors' time and resources, it's been difficult to have insurance fraud cases prosecuted in many states. One way to alleviate this problem is to fund additional prosecutors to prosecute insurance fraud exclusively. Massachusetts currently has dedicated prosecutors placed in its fraud bureau solely to prosecute insurance fraud cases. Part of the proceeds from the civil fines collected by the fraud bureau can be earmarked to county or state prosecutors.

California has initiated a grant program that assists district attorneys prosecuting insurance fraud. Other states are contemplating similar programs. Pennsylvania's fraud law establishes a fund to assist in the prosecution of fraud cases. The monies would be distributed by an authority giving grants to local prosecutors.

California's grant programs could be a model for other states' efforts to curtail insurance fraud. To ensure such programs are implemented, states may have to provide for this earmarking within the regular budget process. Also, there should be adequate oversight to ensure the funds are used to prosecute insurance fraud

and not diverted to other programs.

Funds also can be used to train prosecutors in insurance fraud, and if possible, train the judiciary concerning the importance of insurance fraud cases so judges fully understand the implications of the cases before them.

Finally, fines could fund education programs for the general public on insurance fraud — what it is, why it should not be tolerated and how the consumer can help in fighting fraud.

3) *General Revenues* — Transferring fines to the state’s general revenues adds money to the coffers. In essence, fines become a “user fee” for those committing insurance fraud. If the bureau is successful, state revenues could increase significantly and the bureau may be seen as a revenue source by government officials. As the amount collected increases, budget writers may increase the bureau’s size and funding so it can collect even more fines. The coalition, however, generally opposes using fraud bureaus as a revenue stream for state government.

Dissenting Commentary

Some insurance executives and fraud bureau chiefs have raised doubts about the effectiveness of civil fines. One concern involves the fairness to victims. In some instances, suspected fraud cases referred by insurers have resulted in the imposition of fines, yet because no criminal action is taken, restitution is not required and the insurer is left to seek restitution in civil court.

If a person has a history of committing fraud and has been running fraud schemes for years, fines may be seen as a cost of doing business. The fear of criminal trial and/or a restitution requirement may be a greater deterrent for some violators.

Another concern deals with the potential loss of police powers. In many states, fraud bureaus with fining authority are governed by the state’s administrative code of conduct and thus, are prohibited from having police powers.

Conclusion

Administrative fines can be an effective tool in fighting insurance fraud if they are part of a larger anti-fraud effort. Fines without the fear of criminal penalties may not adequately deter people from committing insurance fraud; fines without restitution or return of profit also may not deter insurance fraud. If individuals see an advantage in committing fraud even after they are fined, they’ll continue to commit fraud. The New York model (fines in addition to the amount of the fraud) clearly takes away the profit motive of insurance fraud and is more of a deterrent.

The coalition clearly recognizes fraud bureaus need to be in a partnership with prosecutors to investigate, detect and prosecute insurance fraud. The most egregious cases and repeated violators should be prosecuted criminally. The coalition believes empowering prosecutors at the beginning of the effort will assure cases are vigorously prosecuted. Using part of the fines to train prosecutors -- as well as grants supporting anti-fraud efforts in prosecutors’ offices -- can help that effort as well. Also, using some of the proceeds for judicial education should be useful. The judiciary may not recognize the magnitude of the insurance fraud problem, but with training, judges can understand why fraud cases should be prosecuted and why it’s in the state’s best interest to sentence violators appropriately.

The coalition also believes that a portion of the fines should be used for consumer education. Simply fining or prosecuting those who commit insurance fraud will be limited in curtailing fraud. Consumer education is an important key to reduce the effect of fraud in the long term.

Suggested Legislative Language

Section 1 - Enforcement

Any person who has been determined by the Commissioner to have committed insurance fraud may receive an administrative penalty of not more than \$10,000 for each act of insurance fraud. Assessment of the penalty shall be determined by the nature, circumstances, extent and gravity of the acts of insurance fraud, any prior history of such act or acts, the degree of culpability and such other matters as may require.

Section 2 - Insurance Fraud Auxiliary Fund and Auxiliary Fund Authority

a) There shall be created an Insurance Fraud Auxiliary Fund within the state to receive all proceeds from administrative fines that are collected under this Act. The funds received shall be used to assist the insurance fraud bureau in the operation of the bureau, to assist the prosecution of the crime of insurance fraud and for education programs to raise the knowledge of the effect of insurance fraud on the cost of insurance.

1) Two-thirds of all funds collected shall be distributed to the insurance fraud bureau to assist in the operation of the bureau.

2) One-third of all funds collected shall be distributed by the Insurance Fraud Auxiliary Fund Authority in grants to county and/or state prosecutors to establish anti-fraud sections, and for education programs to include training of prosecutors, judges and the education of the general public on the effect of insurance fraud on the cost of insurance.

b) There shall be created an Insurance Fraud Auxiliary Fund Authority to administer the funds within the Insurance Fraud Auxiliary Fund.

1) The Auxiliary Fund Authority shall be composed of seven members:

a) the attorney general.

b) the commissioner of insurance

c) one shall be appointed by the governor, who shall be a representative of insurance consumers in the state.

d) one shall be appointed by the attorney general.

e) one shall be appointed by the commissioner of insurance, who shall be a representative of the insurance industry doing business in the state.

f) one shall be appointed by the speaker of the state house.

g) one shall be appointed by the president of the senate.

2) The commissioner of insurance shall serve as chair of the authority.

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- 3) The Authority shall meet to consider the distribution of funds as prescribed by this Act:
- a) to state, county and local prosecutors for insurance fraud prosecution efforts to include but not limited to hiring and training of prosecutors and investigators solely for the purpose of prosecuting insurance fraud;
 - b) to the state, county and local prosecutors as well as state police and other local law enforcement to establish insurance anti-fraud education programs;
 - c) to the state judiciary to establish education programs for state judges on the importance of the state's insurance fraud laws;
 - d) to researchers to conduct studies in insurance fraud prevention and education programs.
- 4) Any member of the Authority who is an elected official or is employed by the state shall not receive any salary for membership on the Authority. All members of the authority shall be reimbursed for all usual expenses incurred in attending the meetings of the authority.
- 5) The office of the commissioner of insurance shall be the office of support for the Authority.
- 6) Except for the attorney general and the commissioner of insurance, the term of office for the authority shall be four years. Except for the attorney general and the commissioner of insurance, no person may serve more than two terms consecutive.
- 7) The Auxiliary Fund Authority shall report to the governor, commissioner of insurance and state legislature yearly on the expenditures from the Auxiliary Fund.

MODEL INSURANCE FRAUD BUREAU ACT

Discussion Paper

Funding Prosecution

Background

The Coalition Against Insurance Fraud believes that without a commitment by prosecutors to bring insurance fraud cases to court, any effort by the industry, consumer or the fraud bureau will be diminished greatly. The key to a successful long-term effort to reduce the cost of fraud on insurance lies with involving everyone in a cohesive program.

Very few states currently have in place programs that will assist prosecutors in prosecuting insurance fraud cases. California levies a surcharge on all automobile policies with part of the proceeds going into a grant program for county district attorneys to use for funding insurance fraud prosecutors. Pennsylvania recently created an insurance fraud trust fund that will collect funds from insurers doing business in the state. An insurance fraud authority will then distribute funds to local prosecutors to use for the prosecution of insurance fraud cases. Georgia recently enacted a new law that set up a similar program to be administered by the insurance commissioner in which funds will be used for the prosecution of insurance fraud.

The coalition has concluded that a system should be designed within each state to foster close working cooperation between the fraud bureau and prosecutors. Too often anecdotal evidence shows that the bureau's recommendations to prosecutors go unheeded because either the prosecutor is unaware of the extent of the crime or does not have adequate resources to prosecute insurance fraud cases along with its other case load. Devoting resources to fraud investigations without followup prosecution is wasteful and does little to curtail fraud.

Recommendation

The coalition believes that states should look into alternative funding options to assist local prosecutors in taking on insurance fraud cases, whether such a program be a part or separate from funding of a fraud bureau.

For instance, states that institute civil or administrative fines may opt to have part of the fine dedicated to a fund for the future prosecution of insurance fraud cases. The coalition's White Paper on Civil Fines discusses this proposal in greater detail.

Prosecutors that are dedicated to insurance fraud cases may be either be housed in the state prosecutor's office or included as part of the insurance fraud bureau.

Innovative approaches should be encouraged and applauded for states to move forward in the prosecution. Fighting fraud is a partnership, and the proper funding for prosecutors is a vital part of that partnership.