



DEPARTMENT OF

**Professional &  
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF LICENSING AND REGISTRATION

**A Report to the Joint Standing Committee on  
Insurance and Financial Services of the  
124<sup>th</sup> Maine Legislature**

**Study on the Feasibility of and Process for the Creation of  
an Insurance Fraud Division within the Bureau of Insurance**

**Submitted by the Bureau of Insurance,  
Department of Professional and Financial Regulation**

**December 2009**

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## Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature directed the Bureau of Insurance to convene a working group of stakeholders to continue a discussion and review of several issues raised before the Committee during its consideration of LD 1285, An Act to Create the Insurance Fraud Division within the Bureau of Insurance. The Bureau was also directed to submit a report to the Committee on behalf of the Working Group with findings and recommendations.

The Bureau conducted three Working Group meetings in August and September 2009. Participants included representatives from 15 insurance companies, several insurance trade associations, the Maine Trial Lawyers Association, the Maine State Fire Marshal's Office, the Maine Workers Compensation Board and the Office of the Maine Attorney General. In addition to their participation in the Working Group sessions, members of the Working Group were invited to provide feedback on two preliminary drafts of this fraud unit report.

The following highlights the issues and legal questions noting when there was agreement, disagreement, and the Bureau's preferred approach:

- Although the extent of the problem is difficult to quantify, most members of the Working Group agreed that insurance fraud is a problem in Maine and that a dedicated fraud unit would be a useful tool to combat fraud. The Maine Trial Lawyers Association noted that there is no evidence of a significant problem.
- All members of the Working Group agreed that if a fraud unit is established, it should have broad authority to investigate all areas of insurance fraud, including claims fraud, premium fraud, fraudulent insurer practices and any other type of fraud that affects the Maine insurance market.
- Penalties for insurance fraud in Maine are adequate and do not need to be addressed at this time.
- Based upon input from stakeholders, the Bureau believes that mandatory reporting of insurance fraud is most appropriately limited to insurers and should not extend to other insurance professionals.
- Although many insurance industry representatives believed that immunity for reporting instances of fraud should be expanded to include insurer-to-insurer immunity, the Bureau believes that an appropriate immunity provision would be similar to that applicable to Fire Marshal investigations, which does not include insurer-to-insurer immunity.
- All members of the Working Group agreed that a fraud unit should be headquartered in the Bureau of Insurance and that the unit would work closely with the Fire Marshal, the Attorney General and local prosecutors. A dedicated prosecutor and resources at the

Office of the Attorney General would be needed to bring cases to trial. Experience in other states with fraud units shows that an effective fraud unit must have adequate resources.

## **Conclusion**

Working Group participants from the insurance industry were generally open to the need for the industry to fund a fraud unit; however, insurance industry members have expressed concerns that the total cost of a fraud unit should be reasonable and that the funding mechanism should be equitable among insurance companies.

# **I. Introduction and Background**

## **A. Legislative Request for Study**

The Maine Legislature has been presented with proposals to create an insurance fraud division within the Bureau of Insurance during the last three legislative sessions. Although the most recent bill, LD 1285, received an “ought not to pass” recommendation from the Joint Standing Committee on Insurance and Financial Services, the Committee asked Superintendent of Insurance Mila Kofman to convene a working group of stakeholders to consider issues that were raised during the Committee’s consideration of the bill. The Superintendent has been asked to report to the Committee on behalf of the Working Group with findings and recommendations.

## **B. Existing Law**

Maine law provides both criminal and civil penalties for insurance fraud, as well as statutory protections to combat fraud.

The Maine Criminal Code makes both “insurance deception” and “deceptive insurance practices” criminal offenses,<sup>1</sup> while the Maine Insurance Code provides civil penalties and administrative enforcement for “fraudulent insurance acts.”<sup>2</sup>

Insurers are currently required to take certain steps in order to combat fraud:

- provide warnings on all insurance applications and claim forms that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company, and that penalties may include imprisonment, fines or a denial of insurance benefits;<sup>3</sup>
- report annually to the Bureau of Insurance on known or suspected Maine-related incidents of insurance fraud;<sup>4</sup>
- implement antifraud plans that provide for specific procedures to prevent, detect and investigate insurance fraud;
- educate employees regarding the plan and fraud detection;

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<sup>1</sup> 17-A M.R.S.A. §§ 354-A, 901-A.

<sup>2</sup> 24-A M.R.S.A. § 2186(7).

<sup>3</sup> 24-A M.R.S.A. § 2186(3).

<sup>4</sup> 24-A M.R.S.A. § 2186(3).

- provide for hiring or contracting with fraud investigators; and
- provide for reporting of insurance fraud to appropriate law enforcement and regulatory authorities.<sup>5</sup>

The Superintendent of Insurance is required to provide the Joint Standing Committee on Insurance and Financial Services with an annual report on insurance fraud.<sup>6</sup>

Relevant information relating to insurance fraud can be shared among authorized investigatory, prosecutorial and regulatory agencies. These agencies include the Attorney General, district attorneys, the Federal Bureau of Investigation, the State Fire Marshal, the Superintendent of Insurance, the Superintendent of Financial Institutions, the U.S. Attorney’s Office, State Police and local law enforcement, and the National Association of Insurance Commissioners.<sup>7</sup> Immunity from civil liability is provided when information is provided to or shared among authorized agencies.<sup>8</sup> Information must remain confidential unless its release is required by a criminal or a civil proceeding.<sup>9</sup>

There is also a process for insurers to apply to the Superintendent of Insurance to conduct an inquest into insurance fraud and to report the findings of the result of the inquest to the insurer.<sup>10</sup> However, the Bureau of Insurance has no information suggesting that this provision has been used within the past 30 years. The Bureau does not have fraud investigators, and most insurers have fraud investigatory capabilities of their own.

### **C. Existing Bureau of Insurance Investigative Processes**

Information regarding insurance fraud may come to the Bureau’s attention in several ways:

- as the result of an investigation by the Special Investigative Unit of an insurer;
- from the Insurance Fraud Unit of another state;
- from a member of the public; or
- through the Bureau’s oversight of insurance companies, insurance producers, and other regulated individuals and business entities.

The Bureau of Insurance is required to advise the Attorney General when it has reason to believe that a person has violated any provision of the Maine Insurance Code or other insurance law,

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<sup>5</sup> 24-A M.R.S.A. § 2186(5).

<sup>6</sup> 24-A M.R.S.A. § 2186(4).

<sup>7</sup> 24-A M.R.S.A. § 2187.

<sup>8</sup> 24-A M.R.S.A. § 2187(5).

<sup>9</sup> 24-A M.R.S.A. § 2187(6).

<sup>10</sup> 24-A M.R.S.A. § 2179.

including but not limited to insurance fraud.<sup>11</sup> The Bureau then works with the Attorney General's Office toward an appropriate resolution of both civil and criminal matters. Close cooperation between all of Maine's investigative agencies is essential to an ability to cooperate with the federal, international and other state authorities often involved.

Currently, no criminal prosecutors exist in Maine whose work focuses solely on insurance fraud. The Office of the Attorney General has a Financial Crimes and Civil Rights Division that oversees the prosecution of white collar and financial crimes, as well as frauds perpetrated against Maine State government, including welfare fraud, Medicaid fraud, tax crimes, securities violations, and a variety of civil rights programs. As discussed below, most stakeholders noted that the lack of a dedicated fraud unit is an impediment to combating fraud.

#### **D. Working Group Process**

In response to the Committee's request, the Bureau sought out an extensive group of potentially interested stakeholders to participate in the Working Group. Superintendent Kofman appointed Deputy Superintendent Timothy Schott, a former criminal prosecutor, to chair the Working Group. In addition to written invitations to participate, Deputy Superintendent Schott initiated personal contact with many groups to encourage them to participate so that their views might be brought forward. Invitations were extended to all who had testified before the Insurance and Financial Services Committee on LD 1285, all who had participated in a similar study conducted in 2005, and other state agencies that the Bureau believed had a significant interest in the project. The Working Group included the State Fire Marshal's Office, the Office of the Attorney General, and the Maine Workers' Compensation Board. Members of the Insurance and Financial Services Committee were also invited to attend and participate in the Working Group.

The Bureau convened meetings of interested stakeholders on August 11, August 20 and September 10, 2009. In addition to Superintendent Kofman and Bureau staff, the following organizations and interested persons participated in one or more Working Group meetings in person or by telephone:

- Insurers: Acadia Insurance Company, Anthem Health Plans of Maine, The Concord Group, Farmers Insurance Group, Hanover Insurance Company, Maine Employers' Mutual Insurance Company, Medical Mutual Insurance Company, One Beacon Insurance Company, Patriot Insurance Company, Patrons Oxford Insurance Company, Progressive Insurance Company, State Farm Insurance Company, State Mutual Insurance Company, The Travelers Insurance Company, and UNUM Group.
- Insurance Industry-related Associations: Maine Association of Insurance Companies (MAIC), American Insurance Association, Property Casualty Insurers Association of America, Maine Insurance Agents Association (MIAA), American Council of Life Insurers, and the National Insurance Crime Bureau (NICB).

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<sup>11</sup> 24-A M.R.S.A. § 214(2).

- State Agencies: Maine Fire Marshal’s Office, Maine Workers Compensation Board, and the Office of the Attorney General.
- Other Organizations: Coalition Against Insurance Fraud (CAIF), Maine Medical Association, Maine Private Investigators Association, and the Maine Trial Lawyers Association (MTLA).
- Legislators: Rep. Leslie Fossel, R-Alna.
- Office of Policy and Legal Analysis: Colleen McCarthy-Reid, Esq.
- Individual: Joseph Greenier.

Participants were also invited to submit written comments on earlier drafts of this report. Comments were submitted by NICB, CAIF, MAIC, AIA, PCI, MADA, Hanover, State Farm, and MTLA.<sup>12</sup>

During her welcoming remarks at the August 10 Working Group meeting, Superintendent Kofman stressed the need to protect businesses and consumers from fraudulent insurance and insurance-like scams (See Appendix B). She specifically noted that we are seeing consumers “ripped off” by illegal car warranties, discount medical cards, and phony associations that lead consumers to believe they are buying real health insurance. Superintendent Kofman asked Working Group members to take a holistic approach and consider all options.

During the first meeting, Bureau staff and Working Group members introduced the following questions for consideration and began discussions around the following questions:

1. Does Maine need a fraud unit?
2. What are the model states for Maine to look at?
3. How would the Insurance Fraud Unit be staffed?
4. How would the Insurance Fraud Unit be funded?

Bureau staff identified states that have implemented Fraud Units in a variety of market conditions, using a variety of organizational models. Insurers were asked to provide a list of model states based on their experiences in those states. For the second meeting, Bureau staff contacted states with fraud units to discuss successes and failures they have had in creating, operating, and sustaining their fraud units. Bureau staff provided an overview of the comparison of states’ fraud units with respect to the issues presented at the first meeting during the second meeting, held Aug. 20. Bureau staff reported back on research into insurance fraud unit statutes

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<sup>12</sup> Written comments and the final report will be posted on the Bureau of Insurance website.

from other states, as well as national models adopted by the CAIF and the National Association of Insurance Commissioners (NAIC).

Stakeholders described their internal fraud units and their experiences with other states' fraud units in the context of the proposed questions.

The third meeting of the Working Group, held Sept. 10, addressed legal questions related to establishing a dedicated fraud unit. In particular, Working Group members addressed whether insurance fraud reporting should be mandatory or voluntary, immunity for fraud reporting, and confidentiality of information collected during an investigation.

The Superintendent of Insurance has sought consensus, where possible, on the various issues considered by the Working Group. While a consensus was achieved on some issues, the Working Group participants have different perspectives on others. The fundamental issues identified by the Working Group are discussed below.

## II. Fundamental Issues Considered by the Working Group

Core Issues	Recommended Approach	Stakeholder Reaction
Mission and purpose	Broad authority	Consensus
Civil or law enforcement authority	Civil authority for Bureau of Insurance personnel	No opposition
Prohibited acts and penalties	No need to revisit existing law	No opposition
Mandatory or voluntary reporting	Mandatory for insurers, voluntary for producers and other licensees	Consensus as to insurers, strong but not unanimous support as to producers
Immunity from liability	Keep current law, do not extend to insurer-to-insurer reporting	Disagreement as to whether to extend immunity to insurer-to-insurer reporting
Confidentiality of investigative information	Maintain and clarify current confidentiality provisions	Consensus
Unit location	Multidisciplinary, headquartered in Bureau of Insurance	No opposition
Fraud Unit staffing	Bureau staff and dedicated AG prosecutor and detective	No consensus on staffing levels
Funding	Insurers fund new unit  Clear formula or method; assessment with cap	Insurers willing to fund but funding mechanism needs to be equitable and reasonable  Varying opinions, with general agreement that the financial obligation on insurers must be predictable
Need for fraud unit	Unable to reach consensus. Funding mechanism must be resolved.	Strong opposition by MTLA, strong support by other stakeholders

### A. Does Maine Need an Insurance Fraud Unit?

Forty-one states and the District of Columbia currently have insurance fraud units. Although most stakeholders expressed the view that an insurance fraud unit in Maine could play a valuable role in the fight against insurance fraud, the MTLA expressed strong concerns.

**Stakeholder comments:** MTLA representatives pointed to a lack of state-specific statistical information supporting the need for a fraud unit in Maine, while proponents cited national trends of increased fraud reports, as well as past reports that support the creation of a fraud unit. MTLA

noted that supporters were relying on anecdotal evidence, and that the existing Financial Crimes Division of the Attorney General’s Office is well suited to handle such cases as may arise.

Superintendent Kofman asked stakeholders to provide concrete data that supports the creation of a fraud unit, including estimates of premium savings and documentation of what has happened in other states after fraud units were created.

Several representatives of the insurance industry supported the creation of a fraud unit because they believe insurance fraud is a significant problem both in Maine and throughout the country. During their presentation on other states’ fraud units, Bureau staff noted that many of the state officials with whom they spoke noted a recent increase in insurance fraud activity, which they generally believe to be related to the economic situation in the United States. Of particular interest, New Hampshire has experienced an increase in suspected insurance fraud cases in the first six months of 2009 and noted several instances of cross-border situations involving persons operating from Maine.

Despite 2,093 cases of suspected insurance fraud in Maine reported by insurers to the Bureau in 2007<sup>13</sup>, there appear to have been relatively few actual referrals to either the NICB or to government agencies. Fifty-three insurers reported referring cases of suspected insurance fraud in 2007 and 2008. The breakdown of referrals is as follows:

<b>Referrals to</b>	<b>2007</b>	<b>2008</b>
District Attorneys	7	4
U.S. Attorney	1	15
U.S. Postal Inspectors and BOI	3	10
Workers’ Compensation Board Fraud and Abuse Unit	36	23
Other law enforcement*	44	34
National Insurance Crime Bureau	209	232
<b>Total</b>	<b>300</b>	<b>318</b>

\*agencies mentioned in this category include the U.S. Secret Service, local police, Bureau of Motor Vehicles and the Fire Marshal’s Office.

The State Fire Marshal’s Office advised the Working Group that from January 1, 2008, to August 10, 2009, there were 216 incendiary fires in Maine. Of those, fraud has been identified as a collateral crime in 35 situations. Many cases are still under investigation, so the number could increase.

Regarding the national trends, a representative from CAIF reiterated the statistics provided during the public hearing on LD 1285 that, per 100,000 people, Maine had 158.4 suspected frauds in comparison to New York at 114, California at 65, and Washington at 12.5. In addition,

<sup>13</sup> The Bureau is required to report annually to the legislature. The 2007 “report on insurance fraud” is available on our webpage. Due to a conversion to on-line reporting, it was necessary for bureau staff to validate the 2008 reported data. It is our estimate that the final 2008 report will be finalized by the end of this calendar year.

CAIF's Web site contains statistical information for 2007 regarding the scope of insurance fraud nationally, but, according to the Web site:

Measuring insurance fraud is an elusive target. No single national agency gathers omnibus fraud statistics. Insurance fraud data thus are relatively piecemeal, making our understanding of insurance fraud an ongoing work in progress. Insurance companies and diverse state and federal agencies each gather fraud data related to their own missions. But the kind, quality, and volume of data they compile vary widely. Independent watchdogs, academics, insurance industry groups and other organizations also conduct research on a variety of fraud topics. Some is national in scope and some state-specific. (See Appendix C).

A representative from MAIC indicated that trade journals have reported an increase in fraud nationally, and a representative from NICB said that NICB has seen an increase from 96 to 118, or 22.9 percent, in questionable claim referrals reported from 2007 to 2008. The types of claim referrals include arsons, vehicle thefts, bodily injury, and medical claims.

CAIF acknowledges in its written comments that "A key question to ask is why is there a discrepancy between the amount of suspected fraud that insurers have reported to the bureau for its annual report and referrals to government agencies." According to CAIF, "The answer is really simple.... Without a specific fraud division, there is little incentive for the reporting of suspected frauds when an insurer knows that law enforcement or prosecutors will not move forward with a case." Some stakeholders made this point at the hearing, noting that even when they have a well-developed case to present, they have difficulty in finding a local prosecutor in Maine to take it on due to resource priorities.

**Bureau:** There is no dispute whether or not there is fraud. The critical question is how widespread the problem is in Maine.

## **B. Mission and Purpose**

The criminal mind is infinitely creative, and insurance fraud consists of a wide range of activities. To some people, the phrase "insurance fraud" suggests what is often referred to as "external fraud," the presentation of fraudulent claims to insurance companies by policyholders, health care providers, and alleged accident victims. However, perpetrators also include insurance producers engaging in such activities as premium theft and deceptive sales practices, insurance company insiders, insurers themselves, and fly-by-night entities operating at the fringes of the industry. As PCI has observed, "fraud is fraud," and must be investigated and prosecuted. Superintendent Kofman made clear that she had strong concerns with the activities of fictitious insurers, bogus health discount cards, and dubious "warranty" arrangements. The Superintendent noted that it is essential that if an insurance fraud unit is established it must be able to protect the public by addressing every type of fraudulent activity.

**Background:** The emphasis of a fraud unit may vary depending on the matters being brought to its attention and market conditions.

MA Example: In Lawrence, Massachusetts, the Insurance Fraud Bureau partnered with the Lawrence Police Department and the Essex County District Attorney to establish a Community Insurance Fraud Initiative. As of June 23, 2009, this initiative had resulted in insurance fraud charges being filed against 369 people including chiropractors, attorneys, runners, and average citizens. Since then, Lawrence has seen a dramatic drop in insurance claim levels. Before the initiative, for every 100 automobile accidents in Lawrence, 141 personal injuries were reported -- nearly four times the statewide average. By 2008 that statistic had dropped to 48 injuries per 100 accidents. Auto insurance premiums for the residents of Lawrence have been reduced by \$40 million.<sup>14</sup>

Fraud division directors in both Colorado and Florida cautioned Bureau staff as to the need to assure that, irrespective of location, the fraud unit's ability to conduct investigations was sufficiently broad to allow it to continue to investigate cases that may have begun as insurance fraud investigations but developed into investigations of other crimes as they progressed.

**Stakeholder comments:** MTLA expressed the concern that insurers would use the threat of referral to an insurance fraud unit as leverage against claimants. MTLA noted the importance of a fraud unit having the authority to investigate all types of fraudulent activity, including fraud committed by persons within the insurance industry as well as members of the public. There was no disagreement from the rest of the Working Group.

Another issue to consider is the type of cases that belong within the authority of the fraud unit. There was consensus that due to limited resources, a fraud unit would have to be strategic. A strategic use of resources would include staged accident rings, phony and inflated claim rings, and unlicensed insurers. In cases in which the fraud unit is not the primary investigating agency, it would partner with local, state, and federal law enforcement agencies and prosecutors.

**Bureau:** Authority should not be limited to investigate particular types of cases but should be broad to respond to market conditions.

## **C. Law Enforcement Status for Investigators**

The Working Group considered whether an insurance fraud unit should have full powers of law enforcement officers or only civil authority, and what types of cases the Insurance Fraud Unit would investigate. The consensus was that civil authority was generally appropriate, but only if civil investigators are well trained and there is adequate access to law enforcement resources when needed.

**Background:** States vary on the scope of authority granted to fraud investigation units. Some larger states, such as Florida, have both criminal and civil investigatory units within their fraud units, while in other states, such as New Hampshire and Montana, the insurance fraud unit investigators are not law enforcement officers. They establish working relationships with other

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<sup>14</sup> June 23, 2009 Press Release of the Massachusetts Insurance Fraud Bureau, "Insurance Bureau CIFI Program Marks Five Years of Progress," <http://www.ifb.org>.

agencies where necessary. It has been noted that typically, law enforcement officers are more expensive to train and employ than civil investigators.

In states where fraud investigators have full law enforcement powers, they are able to serve search warrants and make arrests. They are authorized to carry weapons and have similar training to other law enforcement officers in their state. While they operate according to criminal investigatory procedures applicable in their states, prosecutorial discretion and information sharing capability with other authorized agencies allow for civil as well as criminal remedies to be pursued as appropriate.

**Stakeholder comments:** One stakeholder recommended that a fraud unit have full law enforcement authority and suggested using the State Fire Marshal's Office as a model. The Maine State Fire Marshal's Office has both a Criminal Division and an Inspection Division, which work together as necessary and appropriate.

Other states and Working Group members reported experiences suggesting that efforts to investigate insurance fraud are most successful when trained, dedicated fraud investigators work closely with dedicated prosecutors to pursue cases to conclusion.

Working Group members and officials with fraud units in other states noted that the staff of insurance fraud investigatory units are heavily populated by persons with significant law enforcement investigatory experience, often former police detectives. Staff with significant experience in the business of insurance are also frequently employed by insurance fraud units.

The director of the Attorney General's Financial Crimes Division noted that there are models within Maine government, such as Maine Revenue Services, for agencies that have criminal investigators who are not certified law enforcement officers. She also noted the cooperative ability of people in various agencies handling civil and criminal cases, and that the issue comes down to training.

**Bureau:** The consensus was that civil authority is generally appropriate but requires proper training of staff.

## **D. Prohibited Acts and Penalties**

The Working Group discussed the existing criminal penalties for insurance fraud, and concluded that they are sufficient and do not need to be revisited.

## **E. Mandatory or Voluntary Reporting**

Currently, although the Maine Insurance Fraud Prevention Act requires insurers to file annual fraud reports on an aggregate basis,<sup>15</sup> reporting of individual incidents of insurance fraud is voluntary. LD 1285 proposed requiring insurers to report the incident to the Superintendent if

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<sup>15</sup> 24-A M.R.S.A. § 2186(4); Bureau of Insurance Rule 920.

they have knowledge or reasonable belief that a fraudulent insurance act has been, is being, or will be committed. Insurance producers and other persons acting on behalf of insurers would have been expressly exempted from this duty. Working Group members agreed that mandatory reporting of cases by insurers would be appropriate. There was also consensus that any member of the public should be able to come forward to report suspected insurance fraud to the fraud unit on a discretionary basis, as provided for in Section 4 of LD 1285. There was disagreement, however, as to whether producers should be required to report insurance fraud.

**Stakeholder comments.** Bureau staff reported that all the states contacted recommended mandatory reporting by insurers of cases of suspected fraud because it gives a better overall picture of the situation, and mandatory reporting allows states to prioritize cases. In order to prevent over-reporting, one insurer advocated “concise language that mandatory reporting occur when there has been an identified violation, rather than mere suspicion.”

MTLA recommended that all licensed personnel be required to report situations in which they suspect fraud to the fraud unit. Such a requirement would include, among others, insurance producers, adjusters, and consultants. MTLA believes this might help uncover situations in which elements within the insurance industry are engaged in illegal behavior, and asserted that limiting mandatory reporting to insurers would be a “fatal flaw.”

The Maine Insurance Agents Association opposed MTLA’s recommendation. They observed that insurance producers are agents of the insurers, and the information producers would be reporting would generally be in the insurers’ reports. MTLA also expressed concern that adequate protection against retaliation (whistleblower protection) would need to be provided to protect producers if they were required to come forward in all situations.

Although not discussed by the Working Group, similar arguments would appear to apply to others employed within the industry, such as claims adjusters. Neither the NAIC nor CAIF Model Insurance Fraud Prevention Acts mandates insurance producers to report insurance fraud, and no information has been provided to the Working Group as to any state that requires it.

**Bureau:** Mandatory fraud reporting is a valuable fraud prevention tool, but the requirement should be limited to insurers, as it is in other states with such requirements. The standard must also be carefully worded to avoid being too broad or too narrow. The “knowledge or reasonable belief” standard used in the current voluntary reporting requirement and proposed in LD 1285 is a reasonable standard.

## **F. Immunity from Liability**

Current Maine law provides immunity from civil liability, in the absence of fraud, malice, or bad faith, to any person reporting fraud to authorized law enforcement or regulatory agencies.<sup>16</sup> The Working Group agreed that this immunity provision should be retained.

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<sup>16</sup> 24-A M.R.S.A. § 2187(4).

There was significant controversy, however, as to whether immunity should be expanded, as proposed in LD 1285, to grant immunity for communications between insurers.

**Stakeholder comments.** The Working Group considered immunity laws from other states. Representatives from the insurance industry, CAIF, and the NICB supported expansion of immunity, asserting that broad immunity assists investigations. Several stakeholders discussed the need to share information with other insurance carriers and identify individuals who have filed multiple claims with multiple insurers. Others described firewalls between companies' special investigation (fraud) units and claims investigations units that often thwart full investigation. One insurer requested that if insurer-to-insurer immunity is not adopted at this time, it remain under advisement.

MTLA questioned the need for insurer-to-insurer immunity and noted that it is "highly unusual" for two private parties to be given immunity with respect to communications in this fashion, especially when the communications in question can have a significant adverse impact on third persons.

A representative from the Fire Marshal's Office noted that while the Office may communicate with multiple insurers regarding a particular investigation, it does not see the need for the insurers to have immunity with respect to their own communications with each other.

When the Superintendent suggested modeling immunity language for the Insurance Fraud Unit after the Fire Marshal's immunity language, there was no disagreement. However, no consensus was reached with regard to insurer-to-insurer immunity.

**Bureau:** No change to the immunity law is recommended at this time. The issue could be revisited subsequently, after experience has been developed with the recommendations in this Report and there has been time to evaluate whether the concerns perceived by the various stakeholders have been addressed.

## **G. Confidentiality**

Currently, the Maine Insurance Fraud Prevention Act, the Arson Reporting Act, and the Criminal History record Information Act all provide broad confidentiality protection for investigative information held by authorized agencies.<sup>17</sup> There was consensus among the Working Group that investigative information relating to insurance fraud held by a state insurance fraud unit should be treated the same as that held by other law enforcement agencies. Accordingly, the confidentiality provisions in any Insurance Fraud Unit legislation should focus on ensuring that the existing laws are harmonized and that consistent standards apply to the insurance fraud unit. MTLA emphasized that the confidentiality provisions should not bar disclosure of closed investigative files or reduce the existing litigation discovery rights of policyholders and their representatives.

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<sup>17</sup> 16 M.R.S.A. § 614; 24-A M.R.S.A. § 2187(6); 25 M.R.S.A. § 2413(1).

## H. Location and Staffing Needs

Of the 42 insurance fraud units currently operating, the majority are located within state insurance departments. LD 1285 had proposed housing the Unit within the Bureau and would give prosecutorial authority to the Office of Attorney General.

The Working Group considered staffing needs for a new fraud unit within the Bureau. Preliminary staffing estimates for a fully effective unit are:

- Bureau: one Director, six investigators, one forensic accountant, one staff attorney, and one clerical support person;
- AG: one Assistant Attorney General and one detective assigned to the Financial Crimes Division, dedicated to the investigation and prosecution of insurance fraud; and
- addressing the unmet funding needs of the State Fire Marshal's Office. A dedicated Insurance Fraud Division will not duplicate the work being done by the Fire Marshal's Office with respect to arson investigations.

When the Bureau circulated this proposal for comment, the MAIC questioned the affordability and urged "a more conservative approach to staffing the unit." AIA and PCI, while they have emphasized their members' willingness to pay what is needed for an effective fraud unit, noted the need to maintain expenses at a reasonable level and justify the proposed staffing requirements. One insurer in its written comments estimated that the annual cost of the Fraud Unit as proposed would be approximately \$750,000, and PCI noted that some stakeholder comments at the Working Group meetings referenced a range of approximately \$400,000 to \$600,000.

The proposed staffing reflects the minimum staff the Bureau estimates to be necessary to take on this new area of responsibility successfully. If state agencies are not provided with resources to investigate fraud and prosecute effectively, then consumers will continue to be adversely affected by fraud. Experience demonstrates that without adequate resources, an insurance fraud unit is destined to fail.

**Background:** While there was consensus that the Bureau of Insurance is the appropriate headquarters for a Maine fraud unit, the states we surveyed agreed that the location of the fraud unit is less important than having the resources needed to fulfill its mission. The key elements for a successful anti-insurance fraud effort identified through the survey of these states included:

- dedicated investigatory resources,
- dedicated prosecutorial resources, and
- the development of working relationships among those involved in the effort.

Most states have dedicated insurance fraud prosecutors within the Attorney General's offices or a similar office, funded through the fraud units. Investigation and prosecution of insurance fraud, however, varied widely from state to state, and the states surveyed indicated that a variety of models can be successful:

- In seven states, the Office of the Attorney General oversees the investigation and prosecution of insurance fraud.
- In Virginia and Louisiana, insurance fraud is investigated by the state police.
- Massachusetts has an independent insurance fraud bureau that is not connected with any government agency.
- In South Carolina, investigations are conducted by the South Carolina Law Enforcement Division (SLED), but cases are then prosecuted by the Insurance Fraud Division of the Office of Attorney General.
- Pennsylvania has an Insurance Fraud Prevention Authority (IFPA) that is an independent government agency.
- Montana has an Enforcement Division that combines market conduct, regulatory enforcement, and fraud investigation functions within the Insurance regulators' regulatory functions.

In Georgia and Montana, there are no dedicated insurance fraud prosecutors. These two states rely on local prosecutors who sometimes receive assistance from the Attorney General's office. Representatives from these states stressed the need for relationship-building and education if it is necessary to rely on outside resources.

**Stakeholder comments:** The State Fire Marshal suggested that the prosecutorial arm of the fraud unit be centralized in the Office of the Attorney General, because local district attorneys would be unlikely to have sufficient insurance fraud caseloads to support dedicated prosecutorial resources. Working Group members did not express strong opinions about where the investigative arm of a fraud unit should be housed. The important concern is that there must be adequate resources for both investigation and prosecution of fraud.

As noted earlier, the MAIC submitted written comments noting that they "and others have always argued for a small beginning to more readily adapt and learn from the growing lessons of a new unit," and expressing concern over "the lack of discussion on actually how the unit would be funded."

**Bureau:** As discussed above, the Bureau cannot support legislation to assume new significant responsibilities without adequate new funding. In 2009, Superintendent Kofman opposed LD 1285 on grounds of inadequate resources.

## I. Funding Options

Although some insurer representatives initially proposed funding an insurance fraud unit out of the Bureau's existing budget, the Superintendent explained at the first Working Group meeting why this would not be practical, and a consensus developed that some form of insurer assessment mechanism would be necessary if a fraud unit were to be established. AIA reiterated in its written comments that its members will be willing to financially support a fraud unit with a dedicated funding source as long as the expenses of the entity are reasonable and the cost of its operation are shared on a fair and equitable basis, and PCI also expressed strong support for the concept. MAIC, however, could not offer unconditional support, and expressed concern that at this time, the concept "has neither costs estimated nor a mechanism to equitably share those unknown costs."

**Assessment mechanisms.** The Working Group examined a variety of special assessment mechanisms used by other states to fund insurance fraud units. The bases for assessments include per-insured or per-policy assessments, assessments based on premium volume, and flat assessments on each insurer. Variations within each of these types of funding mechanisms are in use. The NAIC has provided the Bureau of Insurance with a summary of assessment mechanisms used to fund insurance fraud units, based on a data call to all state insurance fraud units (See Appendix D).

**Stakeholder comments:** After initially expressing the preference that a fraud unit could be financed out of existing resources, insurers recognized that they would have to pay an assessment of some type to fund any insurance fraud unit that might be created in Maine. They were concerned about the negative impact of a surcharge on policies, one company paying a larger share than others, and the possibility of a retaliatory tax. While many of the stakeholders expressed support for a formula, specific methodology, or flat assessment with a cap, they reserved support for a special assessment until details of a specific proposal are known. The MAIC in its written comments was troubled by the lack of specificity, asserting "that the industry could not move forward unless there was a clear and accurate way to predict the costs, not only of the unit, but to each carrier doing business in the state."

CAIF emphasized the importance of a funding mechanism that is not limited to investigations, but also provides the resources to ensure that cases will be prosecuted. CAIF expressed confidence that this can be done without an undue burden on insurers.

Representative Leslie Fossel expressed concern with the risk that dedicated funding might be used to fund other state programs.

In written feedback, one commentator suggested "some mention of awards, fines, and settlements intermittently accruing to the Unit." This is not how penalties are traditionally allocated in Maine, and was not raised by stakeholders as an option in the Working Group. This suggestion raises concern about how reliable this option is for a core revenue source, as experience in states that have tried that approach has demonstrated. Conflict of interest issues also need to be considered.

**Bureau:** Should a fraud unit be established, adequate resources and a funding mechanism from the insurance industry would need to be established.

### **III. Conclusion**

The Working Group's discussions have been informative and productive, as evidenced by the range of issues where there has been broad agreement. These discussions involved researching and discussing legal and market issues and significant time contributions by the members of the working group. However, two critical issues remain. The first is whether or not a fraud unit is necessary – many stakeholders cited the need for creating a fraud unit. The other issue that was not resolved is funding. An appropriate and adequate funding mechanism by the insurance industry would need to be developed. Insurance industry stakeholders expressed a willingness to continue to work on this issue.

## APPENDIX A

SENATE

PETER B. BOWMAN, CHAIR  
JUSTIN L. ALFOND  
EARLE L. MCCORMICK

COLLEEN MCCARTHY REID, LEGISLATIVE ANALYST  
JENNIFER RITCH-SMITH, COMMITTEE CLERK



HOUSE

SHARON ANGLIN TREAT, CHAIR  
CHARLES R. PRIEST  
PAULETTE G. BEAUDOIN  
HENRY E.M. BECK  
ADAM GOODE  
EDWARD P. LEGG  
TERRY K. MORRISON  
WESLEY E. RICHARDSON  
WINDOL C. WEAVER  
LESLIE T. FOSSEL

STATE OF MAINE

ONE HUNDRED AND TWENTY-FOURTH LEGISLATURE

COMMITTEE ON INSURANCE AND FINANCIAL SERVICES

June 10, 2009

Mila Kofman  
Superintendent  
Bureau of Insurance  
34 State House Station  
Augusta, Maine 04333-0034

Dear Superintendent Kofman,

As you know, the Joint Standing Committee on Insurance and Financial Services recently considered LD 1285, An Act to Create the Insurance Fraud Division within the Department of Professional and Financial Regulation, Bureau of Insurance. During the committee's consideration of LD 1285, several issues were raised, including the oversight, administration and financial resources of the Fraud Division and the current investigation and prosecution of suspected insurance fraud by the Bureau of Insurance, District Attorneys and the Department of Attorney General. In order to continue discussion and review of these issues, we are writing to ask that the Bureau of Insurance convene a working group of stakeholders, including representatives of the Attorney General, insurance companies, insurance producers and other organizations that submitted testimony on LD 1285.

We request that the Bureau submit a report on behalf of the working group with its findings and any recommendations, including recommendations for legislation, to the committee on or before November 13, 2009. We also would like you to notify committee members and staff of any working group meetings so interested members may attend. Please contact us or our legislative analyst, Colleen McCarthy Reid, if you have any questions or would like additional information. Thank you for your consideration of our request.

Sincerely,

Handwritten signature of Peter B. Bowman in cursive.

Peter B. Bowman  
Senate Chair

Handwritten signature of Sharon Anglin Treat in cursive.

Sharon Anglin Treat  
House Chair

## APPENDIX B

## INTRODUCTION AND BACKGROUND SUPERINTENDENT MILA KOFMAN

GOOD AFTERNOON AND THANK YOU TO EACH OF YOU FOR COMING

The Joint Standing Committee on Insurance and Financial Services recently considered LD 1285 (a bill to create an insurance fraud division within the Bureau of insurance), sponsored by Senator Nancy Sullivan. Several issues were raised during the committee's public hearings. Consequently, the Committee asked the Bureau to convene a working group of stakeholders, including the Attorney General, insurance companies, insurance producers, and others who testified. The Committee asked the Bureau to submit a report on findings and recommendations, including recommendations for legislation to the committee. This is the first of three meetings the working group will have.

I welcome this opportunity. As some of you know, while on faculty at Georgetown University, I was the first one in the country to document the third cycle of health insurance scams; research that led to a U.S. Senate hearing and a GAO report. The experience of serving as an expert witness in criminal prosecutions, and having testified in state and federal courts, along with my examination of state regulatory efforts, state prosecutions, the role of federal law enforcement including the FBI and the U.S. Postal Inspector, U.S. Attorneys Offices and the Department of Justice have certainly informed my view on insurance fraud. When government fails to protect businesses and individual consumers from the criminal element, it is a failure. In fact, I led the effort at the NAIC to pass a model law making it a felony to sell phony insurance -- not just a misdemeanor but a felony.

Given the nation's economic downturn, I am especially concerned about increased fraudulent activities. We have started to see consumers ripped off by illegal car warranties, discount medical cards and phony associations leading consumers to believe they are buying real health insurance.

Fraud and scams increase when the economy tanks. We all know that. While I expect insurers to be concerned about fraud on them -- a real concern -- I'm concerned about fraud on consumers by scammers -- also a very real concern.

My goal is to have an open and honest discussion of the issues. My intent is to address the issues in a holistic way -- looking at fraud prevention, mitigation, and deterrence. We will discuss effective investigations that lead to effective

prosecutions; we will look at the courts and response to white collar crimes. We will have to address the very real issue of resources both at the Bureau of Insurance, the Attorney General's Office, the Fire Marshal's office and other state agencies involved in investigating and/or prosecuting insurance fraud.

So welcome to this working group. I am optimistic that the different perspectives and the substantive challenges will be addressed in a holistic, comprehensive, and balanced way.

I would like to thank Senator Nancy Sullivan for her long commitment and leadership on this issue, seeking to address insurance fraud issues through legislation. In fact the Bureau studied this issue and reported to the legislature in 2005.

I would like to thank Senator Bowman, Representative Treat, and the members of the IFS Committee and the Committee's legislative analyst Colleen McCarthy Reid for their work on this issue. Today, Rep. Fossel is here to help with this effort and I appreciate his commitment to this very important issue.

I would like to give our legislators an opportunity to introduce themselves, and then I would like to go around the room and have each one of you state your name and affiliation. I will now turn this over to Deputy Superintendent Tim Schott, who, as some of you know, is a former prosecutor. I have asked Tim to lead this effort on behalf of the Bureau.

## APPENDIX C

From Coalition Against Insurance Fraud Website, [www.insurancefraud.org/stats.htm](http://www.insurancefraud.org/stats.htm).

## Go figure: fraud data

Measuring insurance fraud is an elusive target. No single national agency gathers omnibus fraud statistics. Insurance fraud data thus are relatively piecemeal, making our understanding of insurance fraud an ongoing work in progress.

Insurance companies and diverse state and federal agencies each gather fraud data related to their own missions. But the kind, quality and volume of data they compile vary widely.

Independent watchdogs, academics, insurance industry groups and other organizations also conduct research on a variety of fraud topics. Some is national in scope, and some is state-specific.

### State insurance fraud bureaus

Fraud bureaus are state agencies charged with investigating suspected insurance schemes within their states. Most states have fraud bureaus, which investigate suspected schemes across most line of insurance. States without multi-line fraud bureaus include: Alabama, Illinois, Indiana, Maine, Michigan, Oregon, Vermont, Wisconsin and Wyoming.

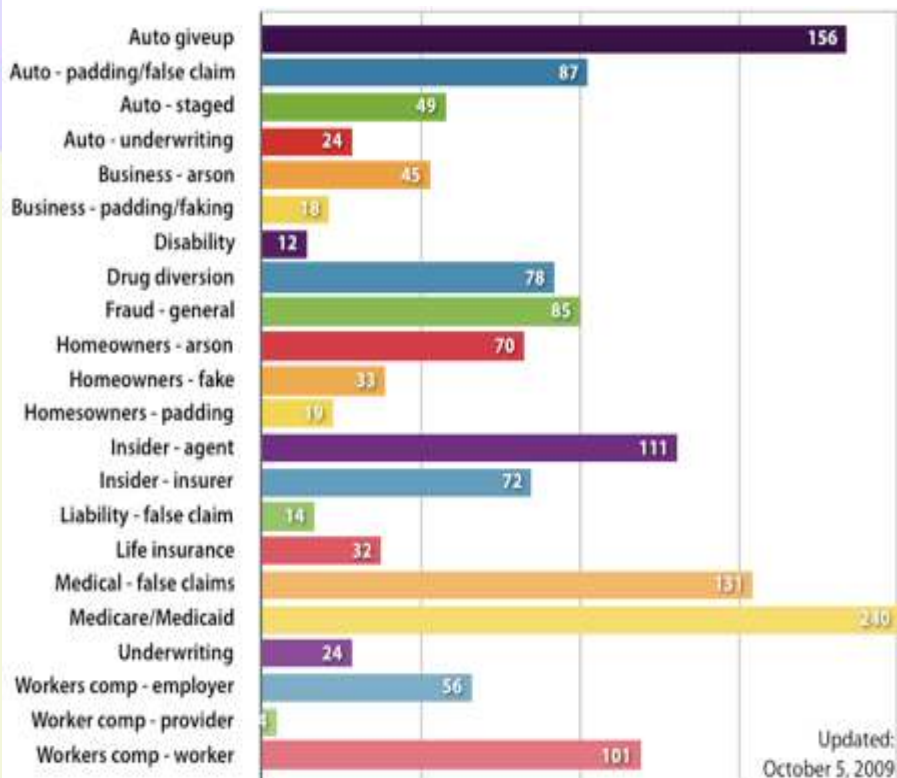
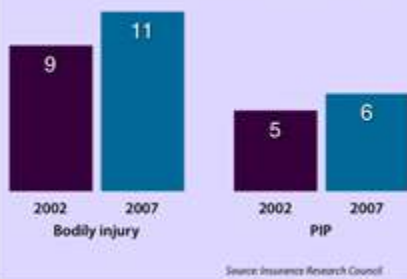
The 2007 annual study of state fraud bureaus by the Coalition Against Insurance Fraud reveals this 2007 combined profile.

Budget	\$147,738,214
Employees	1,694
Referrals	115,062
Cases opened	31,654
Arrests	4,848
Presentations to prosecutors	5,936
Convictions	4,228
Civil actions	7,672
Restitution ordered	\$179,036,100

### Cases reported by the news media so far in 2009.

#### By type of fraud

## Percentage of fraudulent claims



### Auto insurance

**Auto bodily injury claims:** Staged-accident rings fleece auto insurers out of billions of dollars a year by billing for unnecessary treatment of phantom injuries. Usually these are bogus soft-tissue injuries such as sore backs or whiplash, which are difficult to medically dispute.

Fraudulent and abusive auto-injury claims are a costly problem. Fraud and "buildup"\* added \$4.8 billion to \$6.8 billion in excess payments to auto injury claims in 2007. That means 13-percent to 18-percent increases in payments under private-passenger auto policies from 2002. (*Insurance Research Council, Nov. 2008*)

Bogus and abusive claims also are rising. They ranged between \$4.3 billion and 5.8 billion in 2002, or between 11 percent and 15 percent of total payments. (*ibid*)

Claims with apparent fraud or buildup were more likely than other claims to involve sprain and strain injuries, and periods of disability. These claimants also were more likely to receive treatment from physical therapists, chiropractors and other alternative medical providers. (*ibid*)

Buildup involves treatment that's excessive but isn't deliberately or criminally fraudulent.

**Underwriting fraud :** Dishonest drivers try to lower auto premiums by dishonestly lying on their insurance application or renewal. Among the ruses: registering their vehicles in locales where premiums are lower; low-balling their stated mileage; and saying a commercial vehicle is used mainly for personal use.

1. Auto insurers lost \$16.1 billion due to premium rating errors in private-passenger premiums in 2007. Premium rating errors account for 10 percent of the \$166 billion in personal auto premiums. Fraud accounts for a portion of these losses. Some drivers will seek to lower their premiums by schemes such as deliberately misrepresenting mileage driven, how the vehicle is used and where it's registered. (*Quality Planning Corporation, 2008*)

### **Staged Accidents**

An effective strategy against staged-accident rings involves creating multi-agency task forces to apply highly focused pressure in targeted locales where the fraud rings operate. The goal is to thwart often-massive fake injury claims by bogus crash victims. Massachusetts, for example, has experienced considerable success with task forces in recent years...

Nearly 1,200 people in 13 communities have been arrested for suspected involvement in staged crashes since Massachusetts began clamping down on widespread accident rings in late 2003. Many have been convicted. Fraud fighters phased in multi-agency task forces in 13 communities amid public outcry after 65-year-old grandmother Altagracia Arias died in a setup crash in September 2003. (Community Fraud Initiative, A Five-Year Retrospective; Automobile Insurers Bureau of Massachusetts and Insurance Fraud Bureau of Massachusetts, 2009)

The number of injuries per 100 accidents has dropped in those communities, from 38 injuries per 100 accidents in 2003 to 26 in 2008. The statewide average dropped from 38 injuries per 100 accidents to 26 over the last five years. (*ibid*)

Drivers in the 13 targeted communities have saved nearly \$252 million in lower premiums total over the four years between 2005 and 2008. Statewide, the savings was \$514 million. (*ibid*)

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### **Workers compensation**

Some businesses illegally try to avoid paying full state-required workers compensation premiums. One scheme involves paying workers off the books because the number of employees is a factor in determining a business's premiums. Another scheme involves misclassifying employees in high-risk jobs as holding lower-risk jobs.

1. At least 50,000 construction workers in New York City — one of four — are paid off the books or misclassified as independent contractors. (*Fiscal Policy Institute, 2007*)
1. Those schemes stole \$489 million in workers compensation premiums, taxes and other expenses in 2005. That figure could reach \$557 million in 2008. (*ibid*)
1. More than 39,500 employers misclassify 704,785 workers — or 10.3 percent of the workforce — throughout New York State each year. (*Linda H. Donahue, James Ryan Lamare, and Fred B. Kotler, Cornell University, 2007*)
1. In construction, 45,474 workers — or 14.8 percent of New York's workforce — are misclassified as independent contractors. (*ibid*)

1. Employers in high-risk California industries may hide up to 75 percent of their payroll — or \$100 billion — for the most-dangerous jobs. This forces honest employers to pay workers comp premiums as much as eight times higher than if everyone paid their fair share. (*Frank Neuhauser and Colleen Donovan, University of California-Berkeley, 2007*)
1. Every \$1 invested in workers compensation anti-fraud efforts has returned \$6.17, or \$260.3 million total in 2006-2007. (*California Insurance Department, 2007 annual report*)
1. Workers comp insurers in Massachusetts lose \$100 million a year in unpaid premiums to businesses that illegally pay workers cash under the table or falsely label employees as independent contractors. (*Social and Economic Costs of Employee Misclassification in Construction, Harvard University, December 2004*)
1. As many as one of seven construction workers in Massachusetts is hired off the books or illegally classified as independent workers. (*ibid*)

### **Consumer attitudes**

Consumer tolerance of insurance fraud remains relatively high, public-opinion polls have consistently shown in recent years. The coalition's study is the newest national research into what people think about this crime.

1. One of five U.S. adults — about 45 million people — say it's acceptable to defraud insurance companies under certain circumstances. Four of five adults think insurance fraud is unethical. (*Four Faces of Insurance Fraud, Coalition Against Insurance Fraud, 2008*)
1. Nearly one of four Americans says it's ok to defraud insurers (8 percent say it's "quite acceptable" to bilk insurers, and 16 percent say it's "somewhat acceptable.") (*Accenture Ltd., 2003*)
1. About one in 10 people agree it's ok to submit claims for items that aren't lost or damaged, or for personal injuries that didn't occur. Two of five people are "not very likely" or "not likely at all" to report someone who defrauded an insurer. (*ibid*)

Consumer tolerance of specific insurance schemes has increased over the last 10 years, reveals the Four Faces study. There is a decline in the number of Americans who think it's unethical to:

1. misrepresent facts on an insurance application to lower their premiums (82 percent today, down from 91 percent in 1997);
1. file a claim for damage that occurred before the damage was covered (85 percent, down from 91 percent);
1. inflate a claim to cover the deductible (84 percent, down from 91 percent); and
1. misrepresent an incident in order to be paid for an uncovered loss (84 percent, down from 92 percent).

Consumer attitudes toward insurance providers also have declined over the last 10 years, according to *Four Faces*:

1. 62 percent of people have a positive attitude about insurance companies (down from 72 percent in 1997); and
1. Fewer than two of five adults feel positively about the insurance industry as a whole (down from slightly more than 50 percent).

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## Health insurance

### In general

The U.S. spends more than \$2 trillion on healthcare annually. At least 3 percent of that spending — or \$68 billion — is lost to fraud each year. (*National Health Care Anti-Fraud Association, 2008*)

More than \$2.4 billion in recoveries for fraud, waste and abuse in federal healthcare programs are expected for the first half of FY 2009 (October 2008 through March 2009). Some 1,415 individuals and organizations also were excluded from federal programs for fraud abuse; 293 criminal actions were brought, as were 243 civil actions. (Semiannual Report to Congress, Office of Inspector General, Department of Health and Human Services, Office, 2009)

### Private health insurance

1. Every \$2 million invested in fighting health-care fraud returns \$17.3 million in recoveries, court-ordered judgments, plus bogus claims that weren't paid and other anti-fraud savings. (*National Health Care Anti-Fraud Association, 2008*)
1. The average health insurer's anti-fraud investigative unit has an annual budget of slightly more than \$1.9 million and 19 fulltime employees. (*ibid*)
1. The average health insurer has 363 open cases in 2007, and each insurer investigation unit handled an average of 791 cases total for 2007. (*ibid*)
1. More than seven of 10 insurer investigative units use fraud-detection software. (*ibid*)

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## Drug diversion

Insurance fraud is a major financier of America's epidemic diversion of addictive prescription drugs such as OxyContin, according to *Prescription for Peril*, a December 2007 report by the Coalition Against Insurance Fraud.

1. Drug diversion costs health insurers up to \$72.5 billion a year in bogus claims involving opioid abuse alone;
1. Private health insurers lose up to \$24.9 billion annually;

1. Diversion costs individual private insurance plans up to \$857 million annually;
1. Nearly half of Aetna's member/pharmacy anti-fraud team's caseload involved prescription benefits in 2006;
1. Expenses of suspected doctor-shopping members of Medco Health Solutions were nearly seven times higher than the monthly cost of members without excessive prescription claims; and
1. Abuse suspects incurred \$41 in claims for office visits and outpatient treatment for every \$1 in narcotic prescription claims against WellPoint.

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### Whistleblower Lawsuits

The federal False Claims Act allows whistleblowers to obtain a portion of any federal civil recoveries stemming from the whistleblower's efforts to expose fraud against programs. Whistleblowers account for a major portion of healthcare convictions because they tend to be insiders at the offending healthcare organizations, and thus have unique access to information needed to charge and convict.

1. \$1.55 billion in civil settlements and judgments from 218 cases in 2007 in which the Department of Health and Human Service was the primary client agency. (*U.S. Department of Justice*)
1. \$13.2 billion in total civil settlements from 3,665 cases from 1987 through 2007. (*ibid*)
1. Whistleblowers received an average of 16.84 percent of recoveries when the federal government intervened. (*Taxpayers Against Insurance Fraud, 2008*)
1. The federal government recovers \$15 for every \$1 invested in False Claims Act health-care investigations and prosecutions. ([Taxpayers Against Fraud, 2008](#))

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### Medicare Fraud

1. Medicare's annual anti-fraud budget is \$465 billion. (*Miami Herald, August 11, 2008*)
1. Medicare and Medicaid made an estimated \$23.7 billion in improper payments in 2007. These included \$10.8 billion for Medicare and \$12.9 billion for Medicaid. Medicare's fee-for-service reduced its error rate from 4.4 percent to 3.9 percent. (*U.S. Office of Management and Budget, 2008*)
1. Medicare and Medicaid lose an estimated \$60 billion or more annually to fraud, including \$2.5 billion in South Florida. (*Miami Herald, August 11, 2008*)
1. Every \$1 spent on Medicare fraud prevention would stop \$10 in fraud. (*U.S. Department of Health and Human Services*) (*Miami Herald*)

1. Medicare spends less than 0.2 cents of every \$1 of its \$456 billion annual budget combating fraud, waste and abuse. (*Miami Herald, August 11, 2008*)
1. Medicare paid dead physicians 478,500 claims totaling up to \$92 million from 2000 to 2007. These claims included 16,548 to 18,240 deceased physicians. (*U.S. Senate Permanent Committee on Investigations, 2008*)
1. Nearly one of three claims (29 percent) Medicare paid for durable medical equipment was erroneous in FY 2006. (*Inspector General report, Department of Health and Human Services, August 2008*)
1. Medicare and private health insurers pay up to \$16 billion a year for needless imaging tests ordered by doctors. (*American College of Radiology, 2004*)

### **Other Medicare Stats**

Medicare paid more than \$1 billion in questionable claims for 18 categories of medical supplies for patients that don't appear to need. The study covered claims between January 2001 and December 2006. The claims included walkers for patients with purported sinus congestion, paraplegia or shoulder injuries. Hundreds of thousands of claims were made for diabetes-related glucose test strips for patients with purported breathing problems, bubonic plague, leprosy or sexual impotence. (U.S. Senate Permanent Subcommittee on Investigations, 2008)

### **Medicaid Fraud**

1. The 50 state Medicaid fraud control units obtained a collective 1,205 convictions, and claimed total recoveries of more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties in FY 2007. (*annual report, Office of Inspector General, U.S. Department of Health and Human Services*)
1. Of the 3,308 persons and entities excluded from participation in Medicare, Medicaid and other federal health care programs in FY 2007, 805 were based on referrals made by state Medicaid fraud control units. (*ibid*)
1. The number of successful civil actions totaled 607. (*ibid*)
2. More than 61 percent of medical providers (4,319 total) banned from state Medicaid programs in 2004 and 2005 didn't show up in the federal database of state-banned providers. This makes it easier for banned providers to set up shop in other states and continue doing business with federal health-insurance programs. (*Office of Inspector General, U.S. Department of Health and Human Services, 2008*)

### **FBI Enforcement (FY 2007)**

The FBI investigates persons and organizations that defraud public and private health-insurance programs. The FBI combats fraud and abuse jointly with other federal, state, and local law-

enforcement agencies, plus the Centers for Medicare and Medicaid Service, private health insurers and other organizations.

1. 2,493 health-fraud [cases](#) investigated, resulting in 839 indictments and 635 convictions. Other cases also are pending plea agreements and trials. (*FBI Financial Crimes Report to the Public, FY 2007*)
1. \$1.12 billion in court-ordered [restitution](#), \$4.4 million in recoveries, \$34 million in fines, and 308 seizures valued at \$61.2 million. (*ibid*)

### Medical Identity Theft

1. Medical identity theft is the fastest-growing form of identity theft. (*World Privacy Forum, 2006*)
1. Between 250,000 and 500,000 Americans have been victimized by medical identity theft. (*World Privacy Forum, 2006*)
1. Medical identity theft comprises about 3 percent (249,000) of 8.3 million overall victims of identity theft. (*Federal Trade Commission, [Identity Theft Survey Report](#), 2007*)
1. Nine million adult Americans (4 percent) believe they or a family member has been victimized by medical identity theft. Just under half (47 percent) believe computerized health records are stolen most often. (*Harris Interactive, 2008*)
1. 75 percent of Americans age 18-49 and 78 percent of Americans age 50-plus are concerned about being victims of identity theft in general. 25 percent of Americans aged 18-49 aren't concerned and 22 percent of Americans age 50-plus aren't concerned. (*AARP public opinion poll, 2008*)
1. 36 percent of Americans age 18-49 and 43 percent of Americans age 50-plus carry their Social Security card in their wallet. (*ibid*)
1. 40 percent of Americans age 18-49 carry and 57 percent of Americans age 50-plus carry their insurance or Medicare card in their wallet with an ID number that is their or their spouse's ID number. (*ibid*)

### IRS enforcement

The IRS combats criminal tax and money laundering violations involving insurance claims and fraud against insurance companies. Agent/broker premium diversion and re-insurance fraud are among the internal fraud schemes. Phony insurance companies, offshore/unlicensed Internet insurers and staged auto accidents are among the external fraud schemes.

1. 30 insurance-fraud investigations initiated
2. 21 prosecutions recommended
3. 21 indictments
4. 12 sentenced

5. 83.3 percent incarceration
6. 19-month average to serve

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### Slip & fall injuries

Swindlers will pretend to slip or trip and injure themselves to fraudulently collect insurance settlements or other payouts. Often the swindlers threaten an expensive lawsuit to extort fast payouts. Businesses are frequent targets.

1. Three percent of slip-and-fall injuries are fraudulent. (*National Floor Safety Institute*)
1. Bogus injury claims and related costs such as litigation amount to nearly \$2 billion a year. (*ibid*)

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### ANTI-FRAUD LEGISLATION

Insurance fraud is a specific crime in every state except Alabama, Oregon and Virginia.

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### Employment & education

1. Employment of insurance fraud investigators, claims adjusters, appraisers and examiners, is expected to grow by 9 percent from 2006 to 2016. This growth is [consistent with the average](#) for all occupations. (*U.S. Department of Labor, Occupational Outlook Handbook, 2008-09 edition*)
1. The education of fraud investigators, adjusters, appraisers and examiners is divided as follows:
  - High school or less: 22 percent
  - Some college, no degree: 17 percent
  - Associate’s degree: 12 percent
  - Bachelor’s degree: 45 percent
  - Graduate degree: 5 percent.(*ibid*)

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### Older statistics

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### People’s Attitudes About Fraud

#### Consumers

Nearly one of four Americans say it’s ok to defraud insurers, says a survey by the consulting firm Accenture Ltd. Some 8 percent say it’s “quite acceptable” to bilk insurers, while 16 percent say it’s “somewhat acceptable.” About one in 10 people agree it’s ok to submit claims for items that aren’t lost or damaged, or for personal injuries that didn’t occur. Two of five people are “not very likely” or “not likely at all” to report someone who ripped of an insurer. [Click here](#) for the complete study. *Accenture Ltd. (2003)*

Nearly one of 10 Americans would commit insurance fraud if they knew they could get away with it. Nearly three of 10 Americans (29 percent) wouldn't report insurance scams committed by someone they know. *Progressive Insurance (2001)*

More than one of three Americans say it's ok to exaggerate insurance claims to make up for the deductible (40 percent in 1997). *Insurance Research Council (2000)*

One of four Americans says it's ok to pad a claim to make up for premiums they've already paid. *Insurance Research Council (2000)*

One of three Americans says it's ok for employees to stay off work and receive workers compensation benefits because they feel pain, even though their doctor says it's ok to return to work. *Insurance Research Council (1999)*

Seven of 10 Americans say workers comp fraud is a widespread problem, and 45 percent say fraud is increasing. *Insurance Research Council (1999)*

One of five employed workers says they've been aware of fraud in their workplace. *Insurance Research Council (1999)*

Four of five Pennsylvanians reviewed their medical bills for accuracy in 1999 (seven of 10 in 1997). *Insurance Fraud Prevention Authority of Pennsylvania (1999)*

Nearly 16 percent of Pennsylvanians say they're willing to receive bogus workers comp payments (25 percent in 1997). *Insurance Fraud Prevention Authority of Pennsylvania (1999)*

Three of four Americans aren't willing to pay more for their auto coverage to allow bad-faith third-party lawsuits. *Insurance Research Council (2000)*

## **Physicians**

Nearly one of three physicians say it's necessary to game the health care system to provide high quality medical care. *Journal of the American Medical Association (2000)*

More than one of three physicians says patients have asked physicians to deceive third-party payers to help the patients obtain coverage for medical services in the last year. *Journal of the American Medical Association (2000)*

One of 10 physicians has reported medical signs or symptoms a patient didn't have in order to help the patient secure coverage for needed treatment or services in the last year. *Journal of the American Medical Association (2000)*

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## **Fraud Losses & Costs**

### **Personal Injury Protection (PIP)**

More than one of every three bodily-injury claims from car crashes involve fraud. *Insurance Research Council (1996)*

17-20 cents of every dollar paid for bodily injury claims from auto policies involves fraud or claim buildup. *Insurance Research Council (1996)*.

Fraud adds \$5.2-\$6.3 billion to the auto premiums that policyholders pay each year. *Insurance Research Council (1996)*

Claims for bodily injuries under the Personal Injury Protection portion of New York's no-fault auto coverage rose 79 percent between 1999 and 2000, compared to 25 percent in all no-fault states. *Insurance Research Council (2001)*

Insurers increased auto premiums up to 25 percent for New York City in 2001. *Insurance Information Institute (2001)*

The average PIP claim is \$7,950 in New York State — 47 percent higher than the national average. *Insurance Information Institute (2001)*

Fraud costs each insured driver in New York State \$75-\$115 per year. *Insurance Information Institute (2001)*

PIP claims in New York State rose nearly one third in 2000, more than twice as fast as second-place Florida. *Insurance Information Institute (2001)*

The average PIP claim in New York State jumped 19 percent over the first nine months of 2000, and 64 percent between 1995 and 3Q 2000. This compares to a 33-percent increase for other states. *Insurance Information Institute (2001)*

Auto insurers in New York pay out nearly twice as much in PIP claims as they collect in premiums. For every \$100 auto insurers received, they paid \$177 in claims through 3Q 2000. *Insurance Information Institute (2001)*

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## **Arson**

Arson and suspected arson account for nearly 500,000 fires a year, or one of every four fires in the U.S. *National Fire Protection Association (1998)*

Only 2 percent of arson or suspect arson fires result in convictions. *National Fire Protection Association (1998)*

Arson and suspected arson are the largest causes of property damage in the U.S. *National Fire Protection Association (1998)*

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## **Anti-Fraud Efforts**

### **State Fraud Bureaus (2001-2002)**

Criminal convictions increased 31 percent. *Coalition Against Insurance Fraud (2004)*

Cases presented for prosecution rose 14 percent. *Coalition Against Insurance Fraud (2004)*

Investigations initiated increased by nearly 18 percent. *Coalition Against Insurance Fraud (2004)*

Referrals of suspected fraudulent actions were up 4.5 percent. *Coalition Against Insurance Fraud (2004)*

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### **Property-casualty insurers**

Fraud is a serious problem, half of all property-casualty insurers say. *Insurance Research Council-Insurance Services Office (2002)*

The amount of fraud their company has experienced has increased over the last three years, more than one of three insurers say. Nearly half say fraud has stayed the same. *Insurance Research Council-Insurance Services Office (2002)*

About 11-30 cents — or more — of every claim dollar is lost to "soft" fraud (smalltime cheating by normally honest people), nearly half of property-casualty insurance companies say. Hardcore scams steal only a small fraction of that money. *Insurance Research Council-Insurance Services Office (2002)*

Only one of four insurers thoroughly investigate cheating on insurance applications. Even fewer insurers investigate insiders such as employees and agents who commit premium fraud. *Research Council-Insurance Services Office (2002)*

More than two of five property-casualty insurers have increased spending to fight fraud over the last three years. More than four of five insurers have formal anti-fraud programs. *Insurance Research Council-Insurance Services Office (2002)*

Nearly three of five insurers say their efforts to combat are only moderately effective, or lower. Research Council-Insurance Services Office (2002) Fraud-control spending by property-casualty insurers rose from \$200 million in 1992 to \$650 million in 1996. *Insurance Research Council (1997)*

98 percent of property-casualty insurers have a fraud-control program, and most insurers have special investigation units. *Insurance Research Council (1997)*

Half of property-casualty insurers have broad, public-information programs directed against fraud. *Insurance Research Council (1997)*

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### **Workers Compensation**

Without workers compensation anti-fraud laws, claims would've been 10.4 percent higher in 1997, the average claim would've been 7.3 percent larger and system costs per worker would've been 18.5 percent higher. *National Council on Compensation Insurance (1999)*

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## Healthcare

In 1996, Congress funded an added \$548 million over seven years for health-care fraud enforcement. *FBI (2001)*

Health insurers save \$11 for every \$1 they spend fighting fraud – an average of \$5.5 million per company in 1998. *Health Insurance Association of America (1999)*.

Federal convictions for health fraud, waste and abuse rose 57 percent between 1999 and 1998. *U.S. Department of Health and Human Services (2000)*

More than nine of 10 health insurers (95 percent) have anti-fraud training for employees, and nearly three of five (56 percent) have fraud hotlines. *Health Insurance Association of America (1999)*

The FBI secured 560 convictions for healthcare fraud in 2001, a four-fold increase from 1992. The bureau also racked up 741 indictments in 2000, up from 615 in 1999. *FBI (2001)*

Medicare lost \$11.9 billion to waste, fraud and mistakes in 2000, half of what was lost five years ago from improper payments to doctors and hospitals. *U.S. Department of Health and Human Services (2001)*

Fraud amounts to 10 percent of U.S. healthcare expenditures. *Government Accounting Office (1992)*, *National Health Care Anti-Fraud Association (2001)*

Seniors and other taxpayers pay up to \$1 billion a year in inflated drug prices due to potential fraud and loopholes in Medicare. The overpayments represented 1/5 of Medicare spending in 2000. *Government Accounting Office (2001)*

80 percent of healthcare fraud is by medical providers, 10 percent is by consumers and the balance is by other sources. *Health Insurance Association of America (1998)*

The U.S. government recovered more than \$8 for every dollar spent fighting health care fraud and abuse by using the False Claims Act. *New Directions for Policy (2001)*

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## Identity Theft

Thieves stole the identities of 700,000 Americans last year. *The Privacy Clearinghouse (2000)*

Identity theft in general cost \$745 million in 1997, up from \$450 million in 1996. *U.S. Secret Service (1998)*

Abuse of Social Security numbers nearly tripled between 1998 and 1999, and four of every five calls to the Social Security Administration's fraud hotline involve identity theft. *Social Security Administration (1999)*

## APPENDIX D

Information received in response to a August 2009 NAIC data call to all states at the request of the Maine Bureau of Insurance that asked the following questions:

1) Does your Insurance Fraud Bureau or Unit receive funding from an assessment?

If Yes: STATE:

Answer:

2) Does your Department receive an assessment intended ONLY for your Fraud Bureau/Unit?

3) What is the assessment based on and how much is the assessment?

4) Please provide citation to the directive or statute that requires the assessment.

**NAIC DATA CALL REGARDING STATE FRAUD UNIT ASSESSMENTS - SURVEY RESULTS**

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
Alaska	No	No. Funding is provided through general appropriation.	Assessment not only for Fraud Bureau.	N/A
Arizona	Yes	Yes, only for the Fraud Unit	The assessment is based on the amount of monies used at the end of each fiscal year for the fraud unit and for the prosecution of fraud. Can assess an insurer up to \$1,050 a year. 1872.86 CIC - General Assessment on all licensed carriers up to \$5,100 per carrier (all goes to fraud unit).	Arizona Revised Statute 20-466.J
California	Yes	Yes, with exceptions	1872.8 CIC - Auto Fraud, \$1 per insured vehicle (split between fraud unit, district attorneys and CHP as determined by statute).  1872.83 CIC - Workers' Compensation Fraud, as determined by Fraud Assessment Commission (Gov. appointees) who make an annual determination on employers (both self-insured and employers covered by an insurance policy) \$10 (ten cent) assessment on each insured under and individual or group policy (split between Fraud Division and local district attorneys as determined by statute). \$50 (50 cent) assessment on each insured vehicle to combat organized auto fraud (split between Fraud Division, local district attorneys, and CHP, as determined by statute). Between 3 and 10 grants available.	1872.86 CIC - General Assessment  1872.8 CIC - Auto Fraud  1872.83 CIC - Workers' Compensation Fraud  1872.85 CIC - Disability and Healthcare Fraud  1874.8 CIC - Organized Auto Fraud
			\$1 per each individual life policy and each individual annuity product with a value of \$15,000 or more (split between the Investigation Division and local district attorneys, as determined by statute).	10127.17 CIC - Life and Annuity Consumer Protection Program

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
Delaware DC	Yes. Special revolving fund to be designated as the Delaware Insurance Fraud Auxiliary Fund. No	No. The cost of the administration and operation of the DE Insurance Fraud Prevention Bureau shall be borne by all insurance companies authorized to transact insurance in DE. No	An assessment of \$550 annually paid by each insurer.	Title 18, Section 2415; 2404 (d)
	Insurance Trust Fund that funds the entire Department operation and also by general assessment of regulated insurers by policy and premium tax.	Insurance Fraud Bureau is admin overhead expense and comes out of overall budget. No separate Fraud Bureau budget. Expense is factored into Insurance Department budget.	None	None
Georgia	Yes, as authorized by the State General Assembly.	Yes. The amount is based on operational budgets of prior years which include personal services, travel, expenditures, etc. The fees are assessed by category of insurers and premium paid. The current fiscal year the special fraud fund was \$3.2 million in assessments.	On July 1, the Commissioner shall assess each insurance company doing business in GA on the following basis: (a) Each insurer with written premium < \$1,000,000.00, including those insurers whose GA written premium is 0 or less than 0, will each be assessed a fixed amount not more than the minimum amount assessed an insurer with Georgia written premium of \$1,000,000.00 or more; (b) Each insurer with written premium is > \$40,000,000.00, but < \$100,000,000.00, an assessment equal to .0045 times the appropriated amount; (c) Each insurer with written premium of \$100,000,000.00 or more, an assessment equal to .0075 times the appropriated amount; and (d) Each insurer not included in (a), (b), or (c) above, an assessment shall be computed on a prorata basis of the remainder of the appropriation for each insurer whose written premium is > \$1,000,000.00 but < \$40,000,000.00; (e) Written premium is premiums written in GA ONLY, including annuity considerations and is determined prior to reinsurance transactions. Written premium is determined from the most recent annual statement.	120-2-72-.05 Participation in Fund; O.C.G.A. § 33-1-17.
Idaho	No Insurance Fraud Unit			
Iowa	No	No	N/A	N/A
Kansas	No	No		
		As line item in the agency budget.	The Agency is funded through premium taxes.	
Kentucky	No	No. The Fraud Division does not receive an assessment. Funded through Agency Funds.		

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
Louisiana Maryland	Yes No (used to, but not anymore)	Yes No	<p>The assessment is calculated on the direct premiums received by each insurer licensed to conduct business in LA, with some exceptions. The total fee is any year cannot exceed an amount equal to .000375 times the annual direct premium dollars received that are subject to the fee. LDOI is given the first \$30,000 for operating costs for assessing collecting and distributing the fee. This remaining amount is then divided among LA State Police (75%) LA Department of Justice (15%), And LA Fraud Units (10%) which works closely together as a Fraud Task Force. The total assessment for the FY 08/09 was nearly \$3.6 million, of which LDOI received \$394,894.</p>	LSA-R.S. 40:1428
Massachusetts Michigan	Yes, the Bureau is independent from DOI No Fraud Bureau; therefore no assessment.	Yes	<p>All costs of administration and operation of the insurance fraud bureau shall be paid as follows: one-half by the members of the Automobile Insurers Bureau, or its successor rating organization licensed under section 8 of chapter 175A of the General Laws and the companies authorized to write private or commercial automobile insurance that are not members of the licensed rating organization, apportioned on the basis of the direct written premium of each company in the most recent calendar year; and one-half by the members of the Workers' Compensation Rating and Inspection Bureau, or its successor organization licensed under section 52C of chapter 152 of the General Laws, and the companies authorized to write workers' compensation insurance that are not members of the licensed rating organization, apportioned on the basis of the direct written premium of each company in the most recent calendar year. The executive director shall determine the estimated costs for the operation of the insurance fraud bureau and upon Bureau approval shall assess the licensed rating organizations and the other nonmem</p>	<p>Enabling statute: St. 1990, c.338; St. 1991, c.398, §99; St. 1996, c.427, §13; and St. 2002, c.279, §5; and AG funding: Section 3 of H 6412 Chapter 399.</p>

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
Mississippi	No	<p>The Insurance Integrity Enforcement Bureau was created by Miss. Code Ann. 7-5-303. The driving force behind the legislation and most of the funding came from the Workers' Compensation Commission. The IFU is located at the Mississippi Attorney General's Office. Our office has concurrent jurisdiction with district attorneys in Mississippi's 82 counties to prosecute insurance fraud; in practice, most local prosecutors are not well equipped for long-term, document intensive white collar investigations and prosecutions.</p>	<p>Each carrier and self-insurer shall be assessed \$250.00. § 71-3-99</p>	<p>Miss Code Ann. 7.5.303; 7.5.305 Funding; formula; § 71-3-99</p>
Nebraska	Yes	<p>Yes, for the Insurance Fraud Prevention Division.</p>	<p>Any insurer doing business in the state is assessed an amount determined by the Director <u>not to exceed \$200 a year</u>. Self insured's not only exceed \$1,000 per year; however, there is a reciprocal agreement among states.</p>	<p>Sections 44-6601 through 44.6606.</p>
Nevada	Yes.	<p>Yes. 15% is retained in Division, 85% goes to Attorney General where the Fraud Unit is located.</p>	<p>The annual amount assessed on each reinsurer that has the authority to assume only reinsurance must not exceed \$500. For <u>all other insurers</u> subject to the annual assessment, the annual amount so assessed to each insurer: (a) Must not exceed \$500, if the total amount of the premiums charged to insureds in this State by the insurer is &lt; \$100,000; (b) Must not exceed \$750, if the total amount of the premiums charged to insureds in this State by the insurer is \$100,000 or more, but &lt; \$1,000,000; (c) Must not exceed \$1,000, if the total amount of the premiums charged to insureds in this State by the insurer is \$1,000,000 or more, but &lt; \$10,000,000; (d) Must not exceed \$1,500, if the total amount of the premiums charged to insureds in this State by the insurer is \$10,000,000 or more, but &lt; \$50,000,000; and (e) Must not exceed \$2,000, if the total amount of the premiums charged to insureds in this State by the insurer is \$50,000,000 or more. 6. The provisions of this section do not apply to an insurer who provides only workers' compensation insurance and pays the N.R.S. 679B.700.</p>	

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
New Hampshire	Yes	No. The Insurance Department is funded through assessment from which the Fraud Unit receives its working capital.	The assessment is intended to fund the activities of the Department, which includes the Fraud Unit's activities.	R.S.A. 400-A:39
New Mexico North Carolina	Yes No	Yes	The rate of assessment not less than two hundred dollars (\$200) and not exceeding one-tenth of one percent of the correctly reported gross written premiums on policies written in NM by the authorized insurers. In calculating the gross direct written premiums for an insurer, all gross direct written premiums for workers' compensation shall be excluded from the calculation.	NM. Stat. Ann 59A-16C-14
Oklahoma	Yes	Yes, with exceptions. 75% of assessment remains with insurance department, 25% is transferred to Attorney General Insurance Fraud Unit revolving fund for the Attorney General in the investigation and prosecution of insurance fraud.	Flat Fee of \$750 per insurer.	36 O.S. Sec 362
Pennsylvania	Yes. Receive grant funding from the Insurance Fraud Authority (IFPA) that is funded by an assessment on the industry (40 O.S. 325.21)	Yes, the funding from the grant is solely used for the Anti Fraud Compliance Division.	Assessment is on industry as a whole of the IFPA and its grantees. The assessment is based on a formula in statute: 40 P.S. 325.23	40 P.S. 325.22 (Powers of IFPA) and 40 P.S. 325.23 (Trust Fund)
Rhode Island	No. The RI Insurance Division does not have a fraud bureau or unit. Various agencies are responsible for investigating fraud.	Yes. The auto theft and insurance fraud unit is funded through assessment.	Funding for the auto theft and insurance fraud unit is funded via assessment per R.I.G.L. 31-50-4. The Office of the Automobile Theft and Insurance Fraud is funded by an annual assessment through insurers authorized to write automobile insurance in the state, in proportion to its market share, in an amount equal to \$1 per year times the total number of registrations per vehicles having a gross weight of 10,000 lbs. or less. Insurers may collect the amount as a policy surcharge, separately identifiable on the policy declaration page or billing. In 2009, approximately \$752,000 was collected to fund the auto theft and insurance fraud unit. Other units are funded separately such as WC Fraud Unit that falls under the RI Dept. of Labor and Training. 28-37-1; 28-37-13.	R.I.G.L. 31-50-4; 28-37-1; 28-37-13

State	Does the Insurance Fraud Unit/Bureau receive funding from an assessment?	Does the Dept. receive an assessment intended ONLY for the Fraud/Bureau Unit?	What is assessment based on? How much is the assessment?	Assessment Statute or Citation
Virginia	Yes	Yes	The assessment is 0.05 of one percent of the direct gross premium income during the preceding calendar year. Assessments are deposited into a special fund designated as "Virginia State Police, Insurance Fraud."	38.2-415
Utah	Yes, the fraud unit is fully funded by an assessment	Yes. The fraud assessment is dedicated for use only by the fraud division. It is non-lapsing and unspent money carries over to the next year. Fraud assessments are based on the annual premiums written for UT risks, annuity considerations, membership fees collected by the insurer, other fees collected, deposit types contract funds, and other considerations in UT.	\$50 for consideration less than \$1 million, \$400 for consideration between \$1, million to \$2.5 million, \$700 for consideration between \$2.5 to \$5 million, \$1,350 for consideration between \$5 million to \$10 million, \$5,150 for consideration between \$10 million to \$50 million, and \$12,350 for consideration greater than \$50 million. This generates approximately \$1.5 million in revenue for the fraud division.	31A-31-108
Washington	Yes. The entire Office of Insurance Commissioner (OIC) is funded from assessments from insurance companies. The unit is part of the overall OIC budget but the fraud unit does not get a specific assessment.	No. No specific assessment for the fraud unit alone.	The regulatory surcharge is assessed for the costs of operating the Office of Insurance Commissioner, not just SIU. The maximum rate for the surcharge is .125%. The rate assessed depends on the type of insurer. regulatory surcharge includes: Health companies multiply total premiums by .9460% minimum fee \$1,000, life/disability companies multiply direct premiums by .1100% minimum fee \$1,000, property/casualty companies multiply direct premiums by .1100% minimum fee \$1,000, title insurers multiply direct premiums by .1100% minimum fee \$1,000.	RCW 48.02.190
West Virginia	No. WV does not receive funding from an assessment for the Fraud Bureau.			
Wyoming	No. Wyoming does not have a fraud unit.	N/A	N/A	